



**HOUSING & COMMUNITY DEVELOPMENT ACT COMMITTEE  
and  
MENTAL HEALTH BOARD**  
Thursday, May 13, 2021  
Remotely at 7:00 pm

**AGENDA**

As the result of an executive order issued by Governor J.B. Pritzker suspending in-person attendance requirements for public meetings, HCDA and MHB members and City staff will be participating in this meeting remotely.

Due to public health concerns, residents will not be able to provide public comment in-person at the meeting. Those wishing to make public comments at the joint meeting of the Housing & Community Development Act Committee and the Mental Health Board may submit written comments in advance or [sign up](#) to provide public comment by phone or video during the meeting by completing the Housing & Community Development Act Committee and Mental Health Board online comment form available by clicking [here](#) or visiting the [HCDA webpage](#) or the [Mental Health Board webpage](#) and clicking on Public Comment Form.

Community members may watch the joint meeting online through the Zoom platform:

Please click this URL to join.

<https://www.google.com/url?q=https://zoom.us/j/92699768105?pwd%3DMmg5TTYzR1hja01MejJDa1ZjQVpoQT09&sa=D&source=calendar&ust=1620740688994000&usg=AOvVaw1hHU2r0b5ciGqx5cAE1d9r>

Passcode: 876505

Or join by phone:

Dial US: +1 312 626 6799

Webinar ID: 926 9976 8105      Passcode: 876505

1. CALL TO ORDER/DECLARATION OF QUORUM
2. SUSPENSION OF THE RULES ALLOWING FOR REMOTE PARTICIPATION
3. 2021 APPLICATIONS FOR REVIEW:
  1. BOOKS & BREAKFAST
  2. CNE - LEARNING TOGETHER
  3. FAMILY FOCUS
  4. HOUSING AUTHORITY OF COOK COUNTY
  5. INFANT WELFARE SOCIETY
  6. JAMES B. MORAN CENTER
  7. METROPOLITAN FAMILY SERVICES

*Order of agenda items is subject to change*

8. NORTH SHORE SENIOR CENTER
9. SHORE COMMUNITY SERVICES
10. TRILOGY, INC.
11. YOUTH JOB CENTER

4. PUBLIC COMMENT

5. OTHER BUSINESS

6. ADJOURNMENT

The next joint meeting of the Housing & Community Development Act Committee and the Mental Health Board will be scheduled on May 18, 2021, and will be the second application review meeting focused on SAFETY NET applications.



2021 Case Management Services Application Review Meeting  
May 13, 2021

**1. Books and Breakfast**

2020 Request	2020 Award	2021 Request	% Increase of 2021 Request over 2020 Award
\$40,000	\$36,750	\$45,000	22%

**2020 Evanston Residents Served: 294**

**Evanston % of total served: 100%**

**2021 Evanston Residents Estimated: 302**

**Evanston % of total served: 100%**

**2020 City Proportion of Actual Budget: 7.6%**

**2021 City Proportion of Proposed Budget: 7.8%**

**FY 2020 Audit – Financial statement presents fairly**

**FY 2020 Single Federal Audit – NA**

2021 Application is for substantially the same service as 2020.

Books & Breakfast provides morning tutoring/academic support, a healthy breakfast, and social-emotional connection to income eligible students identified by teachers and school social workers as needing additional support. Prior to the pandemic, the agency had Site Directors and tutors at 5 schools; with virtual services, enrollment expanded by 6 schools for a total of 11. On site services are planned to resume Fall 2021 with 5 school sites that will expand to 3 additional schools including Dewey. The agency hopes to expand services to bilingual students/dual language learners in Dewey's TWI program by hiring a Spanish speaking Site Director. Agency supports approximately 45% males/55% females, 56% of participants identify as Black, 38% are Latinx, 5% are white; agency prioritizes students on free/reduced lunch. Agency is able to serve current population, but the Executive Director is covering Site Director duties and this is not sustainable. The ability to place staff at 3 proposed new sites is dependent on funding

Agency has a network of over 400 tutors, including student volunteers from Northwestern and ETHS, that connect with participants. Site Directors (SDs) connect with participants daily throughout the school year and pair Tutors with participants. SDs also create and monitor service plans that identify student area(s) of focus and strategies for improvement. These plans are shared with tutors supporting participants and are evaluated weekly. SDs are also in contact with families monthly to assess household needs. Tutors are trained quarterly and meet weekly with SDs to review participants. Staff and board include people of color and program works to recruit volunteers who reflect population served.



Agency surveys participating households to understand additional needs and primarily refers participants to enrichment programs (e.g., YWCA swimming, Evanston Art Center, Mudlark Theater, DIME, COPE, Moran Center) but also refers to Connections and Erie Family when more complex needs of the family/HH are identified. Agency recognizes the opportunity to strengthen documentation around referral process; currently, notes are kept in documents and excel files. Proposed outcomes are measured by attendance, homework completion, meals/school supplies provided and contact with parents. Majority of program budget comes from donations and grants; award would support Site Directors at three locations including Dewey and the Director of Family and Community Engagement.

## 2. Childcare Network of Evanston – Learning Together

2020 Request	2020 Award	2021 Request	% Increase of 2021 Request over 2020 Award
\$50,000	\$47,025	\$63,400	35%

**2020 Evanston Residents Served: 29**

**Evanston % of total served: 78%**

**2021 Evanston Residents Estimated: 48**

**Evanston % of total served: 80%**

**2020 City Proportion of Actual Budget: 39%**

**2021 City Proportion of Proposed Budget: 47%**

**FY 2019 Audit – Financial statement presents fairly**

**FY 2019 Single Federal Audit – No findings identified**

2021 application is for substantially the same service as 2020.

Childcare Network of Evanston’s Learning Together program provides free mental health, speech-language, occupational and other developmental therapeutic services to children (2-5 years old) who are enrolled in 6 early childhood programs primarily serving low/moderate income residents; children are referred by parents/guardians or center teachers. Population served in prior year identified as 68% Black, 14% white, 8% Latinx, 5% Asian, and 8% multiracial; 86% of households identify as low/moderate income and 59% of participants are from single-parent households.

Agency has the capacity to provide free service to all who request them, but during periods of high demand, wait times can vary based on funding. Entire budget is grant based and majority of City award is passed through to contract specialists; size of award would impact wait times and number of service hours provided to participants. Two case managers supervise consultants and also provide therapeutic services; both have approximately 20 participants per caseload and meet monthly to assess progress and coordinate services. Case managers and therapists are predominantly white. Childrens’ service plans are created with parents and reviewed quarterly; plans include identification of therapeutic services provided and frequency of delivery, family



education/engagement, and referrals to additional resources to support goal attainment. Agency is currently working to expand database (ChildPlus) to better capture records and referrals; referrals typically include additional therapeutic services, pediatricians and dentists all of whom must accept Medicaid.

### 3. Family Focus – Afterschool Program

2020 Request	2020 Award	2021 Request	% Increase of 2021 Request over 2020 Award
\$65,000	\$47,025*	\$125,000	110%

**2020 Evanston Residents Served: 218**

**Evanston % of total served: 100%**

**2021 Evanston Residents Estimated: 258**

**Evanston % of total served: 100%**

**2020 City Proportion of Actual Budget: 39%**

**2021 City Proportion of Proposed Budget: 53%**

**FY 2019 Audit – Financial statement presents fairly**

**FY 2019 Single Federal Audit – No Findings identified**

\*Prior year award supported after school and summer services only. This request includes Early Childhood Home Visiting, Family Advocacy Center, and Grandparents Raising Grandchildren.

Family Focus provides 4 programs to primarily Black and Latinx residents in the 5<sup>th</sup> ward who are disproportionately low-income. **After school and summer services:** available to students from 3rd through 8th grade from 3 PM-6 PM, Monday – Friday, during holidays throughout the school year, and for 7 weeks during the summer. Programming provides STEM (Science, Technology, Engineering, and Mathematics), Literacy, visual and performing arts, and life skills training and social-emotional skills. **Early Childhood Home Visiting:** available to families with children 0 to 3 years old using Parents As Teachers (PAT) curriculum to positively impact social, emotional and cognitive development in partnership with parents. Progress of children is monitored by home visitors to ensure milestones are met. **Family Advocacy Center:** provides parenting classes and individual support to DCFS-involved families with complex needs including court advocacy, supervised parental visits, and connection to community resources; all participating families are referred by DCFS. **Grandparents Raising Grandchildren:** offers peer support and connections to community resources. Referrals for all programs come from Dist. 65 teachers and social workers, City staff (Youth & Young Adult Div.), and nonprofit organizations including CEDA, WIC and Curt’s Cafe.

All four programs include case management elements provided by social workers, family advocates, or home visitors. Staff are responsible for assessing households, identifying holistic needs, and providing connections to services; staff have approximately 25 households on each caseload. Average length of engagement is 6-18 months; participants of family services programs meet with staff twice per month for approximately 1-2 hours with phone calls happening in



between meetings. Staff is diverse and reflects the population served. Historically, agency has requested funds for after school programming; this request would support additional programs that offer similar support services to families. The agency does maintain wait lists for all programs and funds would be used to hire additional staff. It is unclear how funds would be applied to staff salaries and how capacity would be affected if not fully funded. Typical referrals for additional services include housing, family therapy and substance use treatment, but specific partners and a tracking system for referrals was not defined. Agency has partnership agreements with Cradle 2 Career, Infant Welfare Society, Dist. 65, DCFS, and CEDA among others.

**4. Housing Authority of Cook County – Case Management for Senior Buildings**

2020 Request	2020 Award	2021 Request	% Increase of 2021 Request over 2020 Award
NA	NA	\$70,000	NA

**2020 Evanston Residents Served: 26**

**Evanston % of total served: 100%**

**2021 Evanston Residents Estimated: 52**

**Evanston % of total served: 100%**

**2020 City Proportion of Actual Budget: 0%**

**2021 City Proportion of Proposed Budget: 70%**

**FY 2020 Audit – Financial statement presents fairly**

**FY 2020 Single Federal Audit – No findings identified**

The Housing Authority of Cook County (HACC) provides deeply subsidized housing for residents who are 55+ years of age or have a disability; approximately 68% identify as BIPOC and all are below 60% AMI. Agency currently has a part-time case manager who provides approximately 13 hours per month at each site, and a partnership with Thresholds to provide biweekly case management services through office hours and site visits (approximately 30 hours per month). The HACC is requesting funding to hire a full time staff member to work with residents at the Jane R. Perlman and the Victor A. Walchirk apartments (200 units total) with the goal of doubling the population served. Residents would continue to have the opportunity to work with both Thresholds and HACC staff. Application states that residents who could benefit from services are reluctant to accept them; the additional staffer would work with property managers to identify residents not engaged in services and build relationships that would result in connections to additional support services and improved quality of life.

Service plans focus on independent living and maintaining or improving health; typical needs include enrollment in and coordination of insurance, benefits and medical services, food provision, support for behavioral health, promotion of socialization, and transportation. All plans are created in partnership with residents using client centered techniques and plans are reviewed twice per year. Documentation of the referral process is not defined and it is unclear how referrals are tracked. Benefits enrollment services are primarily online and it is clear that residents would



benefit from assistance if they are willing to accept help. It is unclear if the agency has sought to establish partnerships with agencies providing similar case management services to seniors and people with disabilities. Because there is low turnover of residents there would be limited opportunity to engage new residents in services on an annual basis. Additionally, it is unclear if continuation of expanded services in future years would be dependent on City funding.

#### 5. Infant Welfare Society – Teen Baby Nursery

2020 Request	2020 Award	2021 Request	% Increase of 2021 Request over 2020 Award
\$65,000	\$57,915	\$75,000	18%

**2020 Evanston Residents Served: 15**

**Evanston % of total served: 83%**

**2021 Evanston Residents Estimated: 20**

**Evanston % of total served: 87%**

**2020 City Proportion of Actual Budget: 13%**

**2021 City Proportion of Proposed Budget: 14%**

**FY 2019 Audit – Financial statement presents fairly**

**FY 2019 Single Federal Audit – No findings identified**

2021 Application is for substantially the same service as 2020.

Infant Welfare Society, specifically the Teen Baby Nursery (TBN), works with young parents 14-23 to provide case management, mentoring, and wrap around services; participants are predominantly Black and Brown and low/moderate income. Program receives referrals from Dist. 65, City staff (Youth & Young Adult Div.), but most participants are referred by other parents and families. Priority is given to families who are homeless, DCFS involved and have children with disabilities. Agency/program has received City funding for many years and award would sustain services. Participants are parents enrolled in high school, college, a job training program or working; their children (ages 0-3) receive NAEYC accredited early childhood education services; typically households have complex needs including housing, employment. TBN can accommodate 16 children and their families which may also include extended members such as grandparent caregivers; turnover occurs when children reach age 5.

Service plans are created at intake by the Family Advocate (FA); identified areas of need include mental health services, workforce development and education, substance abuse treatment, and housing. Outcomes are achieved using SMART goal setting process. Strengths based assessments are completed 3 times per year, education workshops/trainings are held monthly and parent meetings, typically 30 minutes to an hour, occur weekly. The FA is also in frequent contact through texts and daily interactions with children and parents. Referrals are made directly by FA and documented; Agency is part of the Evanston Collective, a holistic group of service providers that supports high-need populations, and partners extensively with a wide network of service providers



throughout the community to meet participants diverse needs. The FA receives professional development regularly; staff is 80% people of color. Historically, award has supported staff salaries.

**6. The James B. Moran Center for Youth Advocacy**

2020 Request	2020 Award	2021 Request	% Increase of 2021 Request over 2020 Award
\$86,000	\$75,500*	\$75,000	-1%

**2020 Evanston Residents Served: 78**

**Evanston % of total served: 80%**

**2021 Evanston Residents Estimated: 93**

**Evanston % of total served: 84%**

**2020 City Proportion of Actual Budget: 8%**

**2021 City Proportion of Proposed Budget: 22%**

**FY 2019 Audit – Financial statement presents fairly**

**FY 2019 Single Federal Audit – NA**

\*Prior year award supported salaries of staff attorneys for the School-Based Civil Legal Clinic and the Education Advocacy Program. This request is to support Social Work/Case Management staff

The James B. Moran Center for Youth Advocacy provides free legal representation, advocacy and trauma-informed counseling to primarily low income children/youth up to age 26 and their families. The majority of people served are people of color; 17% of participants identify as homeless and 37% of youths served reside in female-headed households. All youth and families served have complex needs; all are stressed by multiple challenges including poverty, housing insecurity, unemployment, substance abuse, violence, mental health challenges and legacies of racial and ethnic oppression. The agency has three programs: Emerging Adult/Juvenile Delinquency Practice, Education Advocacy Program (EAP) and the School-Based Civil Legal Clinic (SBCLC). The EAP provides advocacy and case management services to children with special needs and their families; the SBCLC supports youth who have civil cases and runs out of three satellite locations (Joseph E. Hill Center, Nichols and Chute middle schools). Funds would be used to support social workers/case management staff and to hire an additional part-time social worker/case manager if full funding were to be awarded. Six staff attorneys refer participants to three social workers; the SW Director has a caseload of 58 while the two social workers have case loads of 24 to 15. If the agency is not able to work with a household in need, referrals are made to agencies offering similar services.

Case managers and participants create service plans which are reviewed monthly and meet at least weekly to track progress; all information is tracked in a system called LegalServer. Participants often need assistance obtaining identification documents, insurance and public benefits. Service plan goals often cover career planning, budgeting, housing, and mental health



needs - all interactions, indicators and outcomes are client driven. Agency recognizes that staff demographics do not reflect population served, and is working on systems to gather and incorporate client feedback into strategic plan and daily operations. Agency works with a wide network of service providers to support broad needs of participants as evidenced by creation of and participation in the Evanston Collective, a safety net of holistic service providers that support target populations; agency has MOUs will participating organizations and participants sign Consents for Release of Information so that information can be shared among providers to support participants.

**7. Metropolitan Family Services – Family Coach Case Management**

2020 Request	2020 Award	2021 Request	% Increase of 2021 Request over 2020 Award
\$ 80,000	\$ 72,270*	\$45,000	-38%

**2020 Evanston Residents Served: 22**

**Evanston % of total served: 100%**

**2021 Evanston Residents Estimated: 30**

**Evanston % of total served: 100%**

**2020 City Proportion of Actual Budget: 59%**

**2021 City Proportion of Proposed Budget: 29%**

**FY 2019 Audit – Financial statement present fairly**

**FY 2019 Single Federal Audit – Agency to provide**

\*Prior year award supported the salaries of a Mental Health Practitioner and a Clinical Program Supervisor.

Metropolitan Family Services provides individual, family and group counseling, advocacy, case management, and the Parenting Fundamentals education program to primarily Black and Latinx, low/moderate income families with children; the agency’s goal is to prevent families from entering the child welfare system. If awarded, City funds would be used to support a bilingual Family Coach (FC) who would manage the referral process to link families to critically needed services. This is a new position and staff would work with approximately 25 families.

This position strengthens the process to refer/enroll families with complex needs including healthcare, housing, basic needs and employment, in needed services identified in service plans created by case managers in partnership with participants. Responsibilities of the position include: identifying resources, contacting providers to determine eligibility requirements and service guidelines, provide information to participants in agency’s case management, and track referral process. The FC would then link participants to service providers through a previously established relationship. Service plans are reviewed/ updated every 6 months; social workers meet with families weekly/bi-weekly when family is initially engaged and then monthly or quarterly as family stabilizes. Frequency of meetings is driven by participants’ needs; length of meetings vary



depending on goals. Common goal areas include basic needs (food, transportation, childcare, health insurance, etc), child well-being and parenting skills, employment/career/ education, legal, financial, physical and mental health/well-being, and family/ friends/relationships. All case notes and documentation is managed using an electronic health records system called SmartCare and client case files.

The FC will be responsible for identifying community resources including employment services, primary care physicians, behavioral health services, and domestic violence services, contacting providers to check guidelines and eligibility, and helping families enroll in and receive services. There are many barriers to accessing services including language barriers, fear of accessing services and the inability to navigate complex systems. While social workers can help families through the service plan process and progress towards goals, the FC would be responsible for working with community resources and providers to strengthen the referral process.

#### **8. North Shore Senior Center – Case Management Services**

<b>2020 Request</b>	<b>2020 Award</b>	<b>2021 Request</b>	<b>% Increase of 2021 Request over 2020 Award</b>
<b>\$35,000</b>	<b>\$31,185</b>	<b>\$30,000</b>	<b>-4%</b>

**2020 Evanston Residents Served: 1,928**

**Evanston % of total served: 10%**

**2021 Evanston Residents Estimated: 2,115**

**Evanston % of total served: 10%**

**2020 City Proportion of Actual Budget: 2%**

**2021 City Proportion of Proposed Budget: 2%**

**FY 2019 Audit – Financial statement presents fairly**

**FY 2019 Single Federal Audit – NA**

2021 Application is for substantially the same service as 2020.

North Shore Senior Center (NSSC) offers home and community-based services that support independent living to primarily low-income seniors and people with disabilities; the population served is approximately 43% people of color, 66% are frail or disabled, and 45% live alone. The agency is located in Northfield; prior to the pandemic the Evanston dedicated staff member would come to the Civic Center to connect with Evanston residents. Services are currently offered over the phone and via Zoom; it is unclear if NSSC staff would be able to offer services at the Levy Center in coordination with City programming and supports, or how in-person services could be provided if the Civic Center remains closed to the public.

The Evanston based Care Coordinator has a caseload of approximately 75 adults; if awarded, funds would be used to support an additional, part-time case management assistant who would also be responsible for additional community outreach. Evanston residents are able to connect with any of





available for years. Most referrals come from State of Illinois referral agencies. It is unclear how City funding would expand services, or improve equity of service delivery for new Evanston residents, or in what program(s) they would be enrolled. HBS expanded to include participants between the ages of 3 and 18; 89% of the population served is 18-64, 61% are male, 61% are white, and 64% have a family member/friend as a guardian. Shore has 5 case managers; average caseload is 12 for the Homes; 17 for CILAs, and 22 for the two HBS staff. Staff is predominantly white. City award would support the Director of Shore Homes, the Director of Home Based Support Services, and a Support Services Professional for the SLA program.

Participants receive funds from the Illinois Department of Human Services typically used for service facilitation, personal support work, developmental training and supported employment. Monthly stipends range from \$2,349 for adults and \$1,566 for children and can be used for services from Shore and/or to pay for a Personal Support Worker. Additional supports include SSI/SSDI and Shore-provided transportation assistance, assistance managing benefits and scheduling medical appointments, and the Supported Employment Program. Case Managers are Qualified Intellectual Disabilities Professionals who are able to meet with clients in their homes weekly. Service plans are created and reviewed annually, client goal tracking quarterly, and daily activity calendars are reviewed weekly to ensure clients meet community integration goals. Referrals are primarily for socialization/enrichment programs with community partners including Northwestern, Jewish Family and Children’s Services, and Maine-Niles Association Special Recreation; participation is tracked through case notes.

**10. Trilogy Inc. – Evanston Mental Health Program**

2020 Request	2020 Award	2021 Request	% Increase of 2021 Request over 2020 Award
\$30,000	\$29,700	\$30,000	8%

**2020 Evanston Residents Served: 90**

**Evanston % of total served: 28%**

**2021 Evanston Residents Estimated: 115**

**Evanston % of total served: 31%**

**2020 City Proportion of Actual Budget: 40%**

**2021 City Proportion of Proposed Budget: 38%**

**FY 2019 Audit – Financial statement presents fairly**

**FY 2019 Single Federal Audit – NA**

2021 Application is for substantially the same service as 2020.

Evanston residents connect to Trilogy’s services through referrals from hospitals, including St. Francis/Amita, Connections for the Homeless and through walk-in hours. To be eligible for services participants must have a diagnosed mental illness and no eligible participants are turned away from services. Once assessed by an intake specialist, participants meet with the Linkage Team for





Evanston residents comprise a small percent of the population served. No one is turned away and all services are offered free of charge. Participants enroll in Work-Readiness Training (WRT) a 10-hour work and life skills course and are then directed to one of two main employment programs under the Out-of-School Youth (OSY) category, CORE and Career Pathways. CORE career advisors have approximately 100 per caseload, Career Pathways advisors work with approximately 25-30 participants.

Within the CORE program, agency has identified justice-involved and homeless youth and agency proposes a service path called “Plugged In: Connecting to Economic Opportunity (CEO)” that links this population to partners within the Evanston Collective: Moran Center for legal assistance, Curt’s Cafe for supported employment, and Connections for the Homeless for housing support. An additional goal is to strengthen partnerships within the Evanston Collective. Referrals from partner agencies will be directed to a point person at the YJC who will function as the lead coordinator of services among the Collective; agency estimates that 20 youth with complex needs will benefit from additional, targeted engagement. It is not clear how City funding would be used to expand programming for clients with deepest/complex needs, as funding would support staff including the Career Pathways Career Advisor, the Out-of-School Youth Career Advisor, the Senior Manager of Programs and Partnerships and the Assistant Manager of Employer Relations.

All participants receive intake/assessment services prior to meeting with a Career Advisor(CA). Meetings with CAs typically last an hour and occur weekly or at participant discretion. CAs create Career Plans using the Smart Goal Plan that map career goals and a timeline for achievement. Once participants are employed, CAs perform “check ins” that follow a structured retention schedule. Participants can increase or decrease frequency of contact as needed. All meetings are documented in YJC’s Exponent Case Management (ECM) database and Career Plans are reviewed quarterly.

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Welcome, Not ?

## City of Evanston

Community Development

## FY 2021 Case Management Services

The City of Evanston is accepting CASE MANAGEMENT SERVICES applications for 2021. This application is not for CDBG Public Facilities & Infrastructure (capital) or Housing programs.

CASE MANAGEMENT SERVICES address the needs of at-risk residents, primarily lower income individuals and families. Case management services provide a single point of accountability for coordination of services and are comprehensive to address the complex needs of the populations served. Case management includes the documentation of services and progress, regular meetings with participants, and connections to additional supports to ensure self-sufficiency and wellness. If your agency is requesting funding for SAFETY NET SERVICES, you must complete and submit a separate online application.

Guidelines for case management services eligible for funding:

Develop client-centered service plans in partnership with the client that have specific, measurable outcomes with strategies and timeframes to achieve them, and document provision of needed support services.

Include regular meetings between clients and case managers on a defined schedule to monitor progress. Meeting frequency is anticipated to vary based on stability of client/household. Frequent meetings and based on the client's progress become less frequent "check in" meetings that ensure continued support, with quarterly or bi-annual reviews and modifications of service plans as needed.

Connect clients to needed support services, and access federal, state, local and private benefits for which they are eligible such as Medicaid, SNAP, WIC, SSI/SSDI, and TANF. Case managers help clients gather documentation and complete applications. Referrals/connections to support services, including those funded with MHB/CDBG, are documented and tracked in participant case files.

Have written policies and procedures for case plans including defining goals, setting timeframes and deadlines to meet objectives, and documenting referrals/support services, with caseload averages of  $\leq 25$

clients. Progress notes or case notes are maintained and included in participant files and document frequency of meetings, types and duration of services and outcomes achieved.

Enroll at least 30% of total participants as new Evanston clients during a 12-month period, and Evanston clients comprise at least 80% of total clients.

### **Requirements** [\[hide this\]](#)

To be eligible for funding, a program must meet the CDBG National Objective of benefiting primarily low- and moderate-income persons (family income does not exceed 80% of the area median income). This may be established in two ways: 1) Limited Clientele - income data are collected from all program participants and 51% or more are income eligible or 2) Presumed Eligible includes abused children, battered spouses or homeless. Priorities for funding include case management programs that work with populations identified as high needs in the 2021 Action Plan: low- and moderate-income Evanston residents, particularly historically underserved people, including people of color, are able to take referrals from City staff and other community partners, and deliver services efficiently and effectively. Applications will be evaluated based on the ability to provide robust case management services to at-risk populations. All applications will be reviewed using an equity lens.

FULL APPLICATIONS MUST BE COMPLETED AND SUBMITTED IN ZOOMGRANTS BY 4PM CDT ON WEDNESDAY, APRIL 21, 2021. All applications must be submitted online through ZoomGrants. Hard copy, faxed or emailed applications will not be accepted. Applications will be reviewed by a joint HCDA /MHB committee at a public meeting tentatively scheduled for Thursday May 13, 2021. A second joint meeting to review applications for SAFETY NET services is tentatively scheduled for May 18, 2021 at 7:00 PM. Meeting dates are subject to change.

### **Restrictions** [\[hide this\]](#)

All funds must be used in accordance with regulations as set forth in 24 CFR 570. All recipients must comply with CDBG and federal cross-cutting requirements including, but not limited to data collection, reporting, and organizational capacity per the federal Omni Circular. Funding is contingent on the City receiving its 2021 Entitlement grant; timing of the release of those funds is undetermined and, based on historical experience, may not occur until Q3 2021 or later.

## **Application Questions**

### **Instructions** [Show/Hide](#)

Following City Council's goal to Ensure Equity in All City Operations, the City is intentionally focusing resources on the advancement of racial equity. When completing the application, please provide information detailing how the program aligns with this goal. Agencies requesting funding must demonstrate how funds will be used to help community members most affected by historical racist practices thrive in the community and/or serve marginalized or disenfranchised community members. Programs requesting funding must demonstrate how the program benefits low- and moderate-income persons and creates capacity to enroll Evanston residents into case management services.

City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## Books and Breakfast **Books & Breakfast**

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 45,000.00** Requested

Submitted: 4/21/2021 11:36:10 AM (Pacific)

### Project Contact

Jennifer Cline

[jenniferc@booksbreakfast.org](mailto:jenniferc@booksbreakfast.org)

Tel: 847-525-2728

### Additional Contacts

*none entered*

### Books and Breakfast

419 Greenwood St.  
Evanston, IL 60201

Telephone 847-477-0716

Fax

Web [www.booksbreakfast.org](http://www.booksbreakfast.org)

### Executive Director

Kim Hammock

[kimh@booksbreakfast.org](mailto:kimh@booksbreakfast.org)

## Application Questions [top](#)

### **1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?**

Every single child enrolled in B&B is an Evanston resident. The children are referred by their District 65 school social worker or classroom teacher and principal. D65 is our only referral source. We serve children and families who live in every ward of the City. About 56% of B&B students self-identify as Black, 38% as Latinx, 5% as white. Ninety-three percent are eligible for free or reduced- priced lunch.

Each fall, school social workers and classroom teachers refer students who need B&B's relationship-based, holistic wrap-around supports. The school principal reviews the referrals and prioritizes students from low-income families as shown by eligibility for free or reduced-priced lunch.

Once a child is enrolled in B&B, his or her siblings are eligible to join B&B when they enter D65, and the entire family participates throughout their time in D65 schools. Students and families engaged in our Morning Program during the academic year are eligible for our Summer Reading Program.

When COVID-19 hit, B&B deepened our partnership with D65 and stepped-up efforts for the 2020-2021 school year. B&B hired more staff, created a new online model, and recruited more volunteers than ever before. Expansion for remote learning includes:

1. More than doubling our reach from 5 to 11 District 65 sites
2. Adding 2 additional TWI sites, thus increasing our support for English Language Learners
3. Increasing our student roster from >150 last year to >300 in 2021
4. Tripling our volunteer team to >300 tutors, including ~100 Northwestern undergrads and ~50 Evanston Township High School students

### **2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.**

Our Approach

B&B partners with D65 to advance educational equity, disrupting the impact of systemic racism on Black and Latinx students and filling the gaps in resources for students from low-income backgrounds. B&B's daily before-school program offers a healthy breakfast, social-emotional connection, and 1:1 academic support by trained volunteers and paid Northwestern University undergrads supervised by B&B case managers, called site directors.

B&B reinforces the belief that all children are valued and capable, specifically speaking against a narrative that devalues children of color and children from low-income backgrounds. B&B exists so that every Evanston student can enter their classroom physically, emotionally, and academically ready to learn. Through strong relationships with students, parents, school social workers, teachers, principals, D65, and peer organizations, B&B connects families to their school community and acts as a bridge to Evanston's broader resources.

#### The Need

In D65, 60% of students come from marginalized communities, while 40% of all students come from low-income backgrounds. Systemic racism perpetuates academic achievement gaps across income levels between white students and those of Black and Latinx heritage in D65.(1) The pandemic and remote learning are making things worse. Experts estimate that using remote learning from March 2020 through January 2021 will likely exacerbate existing achievement gaps by 15-20%.(2)

Time away from school, social isolation, and other COVID-19-related issues also impact social-emotional health in a racially skewed way.(3)(4) Limited social interaction has diminished social and emotional skills for some children, especially the youngest ones, as early childhood is critical for building these skills.(5) The disproportionate economic impact on Black and Latinx Americans and women is likely to linger,(6)(7)(8) leaving 1 in 4 children at increased risk of hunger.(9) COVID-19 also laid bare profound racial injustices. The cumulative toll of these stressors puts B&B students at increased risk for PTSD over the long term.(10)

Yet, research confirms that caring relationships with trusted adults empowers young people to succeed.(11)(12)(13)(14) One large study of students participating in a relationship-based, holistic program suggests making gains in social-emotional skills is similar to gaining an entire school year of achievement growth in math or English.(15)

City funds will fuel emergency online growth for remote learning in the current school year. When school buildings re-open in the fall, the funding will also help launch 3 more in-person sites next year, allowing us to continue supporting as many students who joined us during remote learning as possible.

See reading list for refs

### **3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

Right now, we have requests to launch new in-person programs next year from leaders at 4 D65 schools.

To meet the urgent need for remote tutoring and social-emotional connection with children of color and those from low-income backgrounds in D65, we engaged in emergency online expansion in the fall of 2020, doubling our capacity. We seek to add 3 additional in-person sites when school buildings reopen.

We've learned so much about rapid growth during the pandemic: expanding staff, increasing capacity to recruit and train volunteers, and enriching relationships with D65, Northwestern and ETHS. We stand ready to grow by up to 3 new in-person sites next year. This would allow us to add to our roster more than 100 of the students enrolled during emergency online growth.

The rate-limiting factor is funding.

### **4. Does demand fluctuate throughout the year? If so, please explain.**

No, but we see a definite increase in the need for our services to address the long-term impact of the COVID-19 crisis and remote learning on Black and Latinx children and their families.

### **5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

We serve students from every Evanston ward. And It is worth noting that B&B is the only non-profit partner working in D65 with grades K-2 (and 3-8), which is critical because the pandemic and remote learning may be taking the highest toll on our youngest learners.

#### Primary Beneficiaries

Every child on our roster is an Evanston resident who is referred by their D65 school social worker or classroom teacher and principal for B&B's relationship-based, holistic services. We then give priority to children qualifying for free or reduced-priced

lunch. In 2021, 93% of students are from low-income families. About 45% of our students are male, and 55% are female.

Fifty-five percent of our students/families self-identify as Black-African American / Non-Hispanic, 33% as White/Hispanic, 5% as White/Non-Hispanic, 5% as Other Multi-Racial/Hispanic, 1.2% as Black-African American & White / Non-Hispanic, 0.8% as American Indian-Alaskan Native / Non-Hispanic, and 0.4% as Asian / Non-Hispanic.

#### Additional Benefits

This grant would also benefit about 400 tutors and community volunteers, including more than 50 Evanston Township High School students. As detailed elsewhere in this application, participating as a tutor or volunteer in B&B offers training, a rich learning experience in the real world, and the opportunity to build authentic relationships with a diverse group of individuals.

Lastly, by supporting B&B's ability to work closely with principals, teachers, school social workers (we support more than 100 educators), parents, and students, the City helps foster entire school communities that value each child and welcome all families. This grant would help offset cost of emergency expansion reaching over 250 children during remote learning, and help enable B&B's launch new in-person sites in up to 3 additional school communities next year.

### **6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

<input type="text" value="302"/>	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
<input type="text" value="302"/>	Unduplicated Evanston residents to be served in 2021	
<input type="text" value="280"/>	Unduplicated low/moderate income people to be served in 2021	
<input type="text" value="294"/>	Unduplicated people served in 2020	
<input type="text" value="294"/>	Unduplicated Evanston residents served in 2020	
<input type="text" value="281"/>	Unduplicated low/moderate income people served in 2020	
<input type="text" value="281"/>	Unduplicated low/moderate income Evanston residents served in 2020	
<input type="text" value="2,034.00"/>	<b>TOTAL</b>	

### **7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

225 enrolled as of Jan 1, 2021. 75 new participants should be added by Dec 31, 2021

### **8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

B&B has a total programming staff of 11:

#### Case Managers

1) Executive Director (Kim Hammock, 8 yrs w/ B&B) is also serving as Dewey & Washington Site Director

Age: 47

Gender: Female

Race: White

Pronouns: she/her/hers

B&B Tenure: 8 years

2) Director of Operations, Lincolnwood & Walker Site Director (Kyle Hanawalt)

Age: 34

Gender: Male

Race: White

Pronouns: he/him/his

B&B Tenure: 6 years

3) Director of Programming, Kingsley, Willard & Orrington Site Director (Tasha Triplett)

Age: 42

Gender: Female

Race/Ethnicity: Black/Non-Hispanic

Pronouns: she/her/hers

B&B Tenure: 4 years

4) Director of Family & Community Engagement, Lincoln & Dawes Site Director (Cara Carothers)

Age: 48

Gender: Female

Race/Ethnicity: Black, Native American/Indigenous, German and Irish descent

Pronouns: she/her/hers

B&B Tenure: 2 years, 3 months

5) Middle School Site Director (Michelle Foster Everly)

Age: 24

Gender: Female

Race: Multiracial (Black & white)

Pronouns: she/her/hers

B&B Tenure: 2 years plus 2 years as a paid NU tutor

Assistant Site Directors were hired for emergency expansion in fall 2020:

6) Dewey & Washington (Kara Roseborough, female, age 25, Black)

7) Lincolnwood & Walker (Miranda Lonzo, female, age 27, Latinx)

8) Kingsley, Willard & Orrington (Mauricio Sosa, male, age 24, Latinx)

9) Dawes (Erika Castillo, female, age 31, Latinx)

10) Dawes (Caroline Scott, female, age 25, white)

11) Middle School (Kevie Yu, female, age 23, Asian American)

All staff have strong connections to Evanston, backgrounds in education, and profound commitment to B&B's mission of advancing racial equity and justice (see bios). Staff range in age from 23-49 years old, 9 of 11 are female, and consists of 3 individuals who identify as Black, 3 as Latinx, 1 as Multi-racial (Black and white), 1 as Asian American and 3 as white.

City funding will directly fuel our capacity to meet demand for growth to serve additional marginalized children and their families. Rapid online expansion is critical to support social-emotional and academic needs during remote learning. Once schools re-open, in-person growth will be needed to address the long-term impact of the pandemic on children from marginalized communities.

Specifically, we seek City funds to go toward salaries for: a Spanish speaking case manager to support an increasing number of English Language Learners; a new site director for Dewey (our largest site), so the executive director may return to leadership and fundraising duties full time, and; our director of family and community engagement who will enhance our ability to refer families to Evanston's resources and follow up on their progress.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

5 case managers each avg. 30 students (during COVID-19, avg. rose to 45), from ~20 families Case managers each supervise 1 ass't site dir. and ~10 paid NU tutors who also develop 1:1 relationships with students to flag issues for early intervention.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

Trauma informed care: "Every interaction is an intervention"(16)

B&B provides culturally relevant, trauma informed care. We help ameliorate the impact of adverse childhood events and other recognized trauma-inducing factors such as racism (explicit, implicit, systematic, and microaggressions),(17) poverty, and disasters.(18) This last factor will likely grow in importance as we face the long-term effects of the pandemic.

We build strong, stable, and nurturing relationships to foster the feeling of belonging that is essential for all students but is imperative for healing students who have experienced trauma. Daily, B&B creates a community where children feel valued and empowered. One way we do this is by cultivating 4 strengths. Called "Academic Mindsets," each is independently associated with increased perseverance, better academic behaviors, and higher grades. They are: 1) I belong in this academic community; 2) I can succeed at this; 3) my ability and my confidence grow with my efforts, and 4) this work has value for me. (19)

**Participant informed goal setting**

While our mission focuses on children, B&B's holistic approach engages their parents and educators to help set social-emotional and academic goals for each B&B student. We do this for all B&B students via written surveys. For children in K-5, site directors also incorporate tutor input and informal student input as they set and revise individualized goals (described in detail elsewhere). B&B's middle school model mentors the students to set and monitor their own goals, creating their own plans to meet them.

**Multi-generational approach**

To support D65 children, B&B serves Evanston families. Since COVID, we've made more than 10,000 calls to parents to assess needs and provide direct support or referrals. We host quarterly family orientations or events. B&B planned to launch a Parent & Family Advisory Board in summer 2020 to help inform and enhance our ability to meet the needs of families more robustly. We hired a part-time staffer to support this advisory board and nurture B&B's long-term relationships with community partners. The pandemic interrupted our plan, and we decided to focus on meeting urgent needs voiced by our B&B families instead. We will take up this project again over the summer of 2021 and hold the first meeting sometime in the coming fall.

#### Partnership

Our approach is predicated on respectful, authentic relationships at every level. B&B site directors are in daily contact with our D65 colleagues about B&B students and families. Because we know the entire family and engage with each child individually every day, we are often the first to see an unmet need and take steps to help. As one B&B mother said, "B&B is always my first call. If they can't help me, they won't stop until someone else can."

Please see reading list for refs

#### **11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

B&B offers a range of internal and external training and professional development opportunities for our staff. We believe training and professional development are integral to our mission and success. Reasons include:

- 1) increasing our capacity to provide high quality care for children and families
- 2) retaining staff and tutors, which is critical to building trust and the long-term, stable relationships B&B children need
- 3) fostering professional and personal growth in staff and tutors, most of whom are members of historically harmed communities and often are native Evanstonians

Internal programming includes weekly sessions where site directors meet to review challenges they have faced. These sessions provide our case managers with insight, techniques, and resources to address clients' needs. Moreover, the sessions offer emotional support to sustain our team as they engage in ongoing, often difficult social equity work and face systemic barriers themselves.

Other external programming for staff includes training on topics such as restorative justice in schools, trauma informed care, racial equity, D65 curriculum, and using D65 technology. B&B staff have also participated in Leadership Evanston and other Evanston Community Foundation training programs designed to nurture the development of a healthy non-profit sector in our City.

On average, these more formal staff training sessions takes place at least quarterly.

At B&B, the minimal level of training required to join the staff includes experience working with children and demonstrated alignment with B&B's mission of advancing racial equity and justice.

In addition, staff from B&B and NU's Leadership Development and Community Engagement team jointly developed and host an annual orientation and quarterly training program for NU tutors. This program includes a beginning-of-year retreat with a tour of Evanston, a D65 partner dinner and multiple visits from Evanston leaders who give context to the work. Quarterly training sessions cover topics including D65 curriculum, social identity, Evanston history, systemic racism in educational systems, and ways to continue to be an advocate for educational equity. In 2021, B&B adapted this training curriculum into a 3-hour online program for community volunteers, which garnered excellent attendance (85 participants) and high marks.

#### **12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

##### Components

A typical morning at B&B includes a good morning hug, a healthy breakfast, and time with an individual tutor. Specifically:

- 1) Healthy Meal -- We offer a source of protein, multiple fresh fruit options and low sugar cereals.
- 2) Daily Academic Focus: Children work with a diverse team of tutors (Northwestern University students, teachers, parents, and community volunteers) on homework or reading. This daily commitment builds strong academic habits and the student's confidence in their ability to succeed.
- 3) Relational Connections: Our staff and tutors provide daily social and emotional support in addition to academic help. Tutors spend time building relationships with individual students and affirming the child's deep value and potential. We strive to maintain a 1:1 student to volunteer ratio, allowing us to provide individualized support. We also serve as the first line of connection for our students' families, reaching out by phone and text, providing direct support or referring them to partner organizations for essential needs such as food, rent assistance, health care, mental health care, and legal assistance. We

augment, connect, and complement -- but never duplicate -- services offered by partner organizations. Central to our work from the start, the importance of this role is magnified by the pandemic and the lingering economic crisis in its wake.

#### Frequency/Duration

During the academic year, B&B site director/case managers meet with their students for an hour five mornings per week. Paid NU tutors commit to meeting with students for an hour three morning per week. Community volunteers commit to meeting with students one hour per week. Site directors reach out to families by call or text at least monthly. B&B summer program for 2021 will engage students over a 5–6-week program. K-5 will meet online and in-person 2-3 times a week, middle school will meet 1-2 times per week. We will hold 2 family and community events and provide book packages and reading incentives every 2-3 weeks in July and August.

#### Engagement

B&B measures student engagement qualitatively and quantitatively. After each session, tutors document the students' affect, confidence, and readiness for school (see sample attachments). Site directors compile tutor forms into weekly summaries to evaluate trends and progress, which inform the next weeks' goals and strategies. We also monitor attendance.

During enrollment, parents commit to bringing students to B&B at least three mornings a week. If a student is absent frequently, site directors call parents to check in. Generally, absences follow a change in family circumstances and site directors engage as needed. For example, helping create carpools when transportation or work schedules are the reason for children missing B&B. If absences continue, we pursue every problem-solving option before removing students from the roster, which is a rare occurrence.

### **13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

#### Established Sites

In September after school begins, D65 school social workers and classroom teachers identify children who need additional support to join our returning B&B students. As principals review these referrals, we ask them to give priority to students who qualify for free or reduced-priced lunch (our income indicator).

We invite families recommended by their principal to join B&B. New and returning families complete a written application, registration form, and consent form. In these forms, we ask permission to verify if the student is eligible for free or reduced-price lunch, but never require documents to avoid creating additional barriers to care.

We then distribute and collect written surveys to parents and teachers about their social-emotional and academic goals for each child.

In October, B&B's Morning Program opens during the hour before school. B&B staff and tutors get to know each child's strengths and identify areas of focus. In our elementary school program, site directors incorporate data gathered from parents and teachers with their observations and input from tutors to create individualized plans for each child. In our middle school program, site directors and tutors also work with the students to create their own goals and plans for the year, fostering executive function skills and increasing students' sense of agency. In both settings, we then share the goals and plans with each student's family and teachers.

#### New Sites

Generally, when B&B launches a new site, this process takes place in January and February.

### **14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

#### Student Plans

Plans outline academic and social-emotional area(s) of focus and strategies to address them (sample attached). For example:

Doesn't interact with others at all, never goes to game stations: Make a plan with her about what her B&B goals are and what OUR hopes/goals are for her

Sluggish, hard to move quickly, rarely turns in homework. Comes to B&B late and hungry every day. Teacher says he needs emotional support, breakfast, and love: Gentle but motivational, firm tutor pairings (Names here) "Peppy" interactions, genuine conversations. Encourage, encourage, encourage!

Struggles and doesn't like others to know. Has a good amount of homework, tries to avoid it, though lately has been working hard. Behavior challenges off and on (rudeness, inappropriate comments): Strong tutor pairings (Names of NU tutors here) Avoid making him feel singled out for anything but praise. Connect and ask about his family. Constantly (but authentically!) encourage his efforts and successes.

## Outcomes

Our primary objective for the 2021-2022 school year will be for at least 75% of our students to show the following because of participating in our morning program:

- increased homework completion
- increased social-emotional readiness for the school day
- increased confidence in their abilities as a learner

Key indicators are “comfort level with the assignment” and “readiness to learn” as described below.

## Progress

Progress is monitored regularly. Daily, all tutors submit a Google form about their interactions with each student to their site director (sample attached). These forms summarize the students’ activities (i.e. homework, reading, remote assignment), comfort level with the assignment (i.e. confident, catching on but could use more practice, etc.) and affect (here & ready to work, ready with some effort, Not willing to work). Site directors track tutor input (sample attached), and follow-up with students, D65 and families as needed. Weekly, site directors meet to review student progress and discuss strategies for challenging situations.

Success is measured qualitatively and quantitatively. We use parent, teacher, and student surveys at start-, mid- and end-of-year. We also track breakfasts served, staff-parent and staff-teacher interactions, hours of tutoring, and homework assignments completed with a tutor. In addition, we hope to begin tracking referrals to partner agencies to inform our continuous improvement.

## Supporting B&B Families

B&B’s relationship-based approach allows us to see and fill unmet needs of B&B families on a regular basis. We also conduct written parent surveys (sample attached) twice each year asking about their needs (i.e. food, clothing, housing, mental health, etc.) and connect them to D65 or Evanston resources beyond the scope of our program. This is the facet of our work we seek to deepen. City funds would enable us to improve our capacity to provide and track this facet of our work.

## **15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

### Plans and documentation

Plans are created in October, are revised in January and April, and final progress is measured in June. Site directors review student plans weekly based on their observations along with input from teachers, parents, tutors, and the students themselves.

### Frequency of Contact

We survey parents and teachers at least twice per year.

### D65 Colleagues

We are in touch with teachers and other D65 staff daily about our students. However, in response to educator feedback, we update them formally about progress toward goals only at mid-term and end of year.

### B&B Families

We update parents on their students’ progress and check in about the situation at home at least monthly.

## **16. Describe a typical client’s pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an “average progression” within the case management relationship?**

The “Average Progression” of B&B Relationships

It all begins with demonstrating we care about the children and their families, establishing B&B as a safe and loving community. We spend the first month getting to know each child, learning each student’s strengths as well as areas that need extra support, and then determining the pace of interventions and evaluations. Once we begin fostering the children’s confidence and gain their trust, we weave in attention to academics. At this point, we develop individualized student plans using input from teachers, parents, tutors, and the students themselves. We also hold family orientations and/or a fall event to bring families together at the school.

At mid-year, we review student plans with teachers, parents, students, and principals to refine the plans for the rest of the year. At this point, staff, tutor and volunteer relationships with students are usually thriving. With community support, we create individualized packages of books, supplies and surprises for each student. Our goal is to keep them engaged over winter break, reinforce how special they are, and demonstrate we will miss them.

In spring, we conduct a final survey and review our progress across the year. We mark the close of the academic year with a celebration of students’ success of the year -- whatever they may be! There is also a family event at the school in the spring, and fifth graders get a completion certificate.

Students in our Morning Program are eligible for our Summer Reading Program, which is also rooted in evidence-based best practices. Summer programming usually includes free swimming lessons at the YWCA and art projects courtesy of Evanston Art Center. We provide individualized packages of books selected based on student interest and abilities, along with reading incentives. During the pandemic, online dance with D.I.M.E., art projects and cooking classes offered fun remote activities when swimming was not an option. Whether in-person or online, families are included in these shared experiences.

B&B's culturally relevant and trauma informed approach realizes that every interaction is an intervention. The activities summarized above level the playing field for youth from historically marginalized communities in Evanston. As one supporter put it, "B&B is about the community's response to the community's needs. That's why it's trusted, effective, and here to stay."

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

We follow FERPA regulations. Case records are documented and maintained on B&B's computer network. We use Google forms, Google sheets and Google docs to create and update our case notes. Please see our response to Questions 13, 14, and 15 for more detail about the process.

We maintain case records using documents including:

1. Beginning of the year teacher survey
2. Beginning of the year registration form
3. Tutor input form -- daily
4. Weekly tutor tracker
5. End of year surveys for parents, teachers, students,
6. Student plans
7. Parent surveys about needs

We also track the number of meals served, tutor hours, staff/parent and staff/teacher contacts, and number of book & supply packages we deliver.

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

B&B students graduate from our program when they graduate from their D65 school.

Elementary school students moving to a middle school with our program participate in sessions for rising 6th graders over the summer and are welcomed into B&B's program tailored for young adolescent students.

If they are moving to a middle school that currently does not have a B&B program, we connect them with a D65 representative or another partner to ease this transition.

Similarly, when B&B middle school students enter high school, we connect them to caring adults there. (For example, a former B&B NU tutor is now a social worker at ETHS.)

As our program grows, and the number of B&B alumni grows, we are heartened to see our community extend. Older siblings often return to say hello and check in.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient.**

**What are the barriers to receiving those services?**

B&B's primary clients are Black and Latinx students in Evanston/Skokie D65. The service they need most is culturally relevant, trauma informed social-emotional support to feel welcome, safe, and confident they can succeed in school. The primary barrier is institutionalized racism, demonstrated by the persistent achievement gap between them and white students across income levels. B&B works to create inclusive, equitable schools that help all children reach their full potential. For example, our most recent pre-pandemic survey shows 100% of principals believe B&B advances racial justice at their school.

B&B students also need academic support and enrichment. With 96% qualifying for free or reduced-priced lunch, barriers include gaps in resources and opportunities compared with white D65 students. B&B provides 1:1 tutoring by caring adults. B&B families are at increased risk for food insecurity, so we provide a healthy breakfast. And it is worth noting that B&B provides a free, supervised environment for children before school, so parents can leave for work knowing their children are safe.

We also provide enrichment such as art and dance. Field trips connect our students to aspects of Evanston life they usually cannot access. For example, we organize trips to Northwestern sporting events and tours of the campus, theater experience through Mudlark, art projects with the Evanston Art Center and swimming lessons at the YWCA.

Through our daily student interaction, B&B sometimes helps uncover a student's need for an Individualized Education Plan

(IEP). Acquiring one usually requires legal intervention in any school district, and D65 is no different. We refer families to the Moran Center who need help navigating the arduous process.

Regular interaction with parents and our written parent surveys find families most often need food, clothing, legal help, mental health services, and help with housing or rent.

Lastly, a major barrier B&B families face is how D65 distributes information. D65 relies on email, which is not easy for most B&B families to access. B&B uses texts and calls to alert our families to key information from D65. This includes information about school, as well as opportunities for summer camp and other enrichment programming. We are encouraged to know the District is considering using phone and text communication in the future.

## **20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

B&B supports Evanston children and families with 3 categories of referrals:

### **1. Internal B&B Services**

We can handle many of the unmet needs we recognize in our students and their families. For example, throughout the pandemic, B&B has distributed packages of books, school supplies, and essential items individually selected for each student every 2-3 weeks. When a site director learns a child needs something, that item is often included in their package. Recently, a site director noticed a child arriving to B&B Online tired for several mornings in a row. The director asked the child why and found out she was watching tv until the wee hours. The child said she would like to read instead but didn't have a lamp to read by. We included a book light with her next package, and now she reads for a bit and gets a full night sleep. These referrals are tracked in our weekly meetings and progress notes.

### **2. Referrals to D65 Resources**

Many of the services family's need are provided by D65, but our families either don't know about them or have difficulty accessing them. These services range from clothing support through ESSCSA, to food support through the PEP fund, and even sometimes access to school social workers. The process here begins with our site directors' monthly contact with families, or when a family calls us. Then, the site director provides the family the contact information within the district. Often, the site director will reach out to the district resource provider and alert them of the family's need. We follow-up with families about the status of our referrals during our monthly check-in process.

### **3. Referrals to External Partners**

The last category of referrals are external partners who provide supports beyond the scope of our program or D65. Most often, these partners are Evanston organizations such as the Moran Center, Connections for the Homeless, or Erie Family Health. During the pandemic, local food banks and government services (such as those providing rent and utility payment assistance) are also common partners. As with D65 referrals, site directors provide families with the contact information, and often reach out to the resource provider to alert them of the families' needs. We follow-up with families about the status of our referrals during our monthly check-in process.

N.B.: We had planned to improve our capacity to track referrals and document their status program-wide in 2020, but handling pandemic-related emergencies took priority. We seek City funding to take up this project again in 2021 and use the resulting data to inform our continuous improvement.

## **21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

B&B is grateful for our ongoing partnerships with D65 and Northwestern. We work extremely well with both organizations. For example, D65's Manager of Equity, Diversity, and Family and Community Engagement, Devon Alexander recently wrote that B&B "epitomizes the type of community engagement partnership needed within the district to transform our educational system for educational racial equity." He says often he wishes B&B was in every D65 school (see letter of support in documents).

We partner with the Leadership Development and Community Engagement Office in Northwestern's Division of Student Affairs to recruit, train and support >40 tutors each year, who become beloved role models and mentors, and provide daily reports to our site directors on each child's affect and needs. We are so thankful to LDCE for absorbing the financial cost of paying these young people for the time they invest in Evanston's children.

B&B also has informal relationships with several Evanston groups to enrich the lives of our B&B students and families: The YWCA offers free swim lessons in the summer to B&B kids, Evanston Art Center, Mudlark Theater, and D.I.M.E all integrate their services into B&B, and we work with COPE to deliver school supplies to families. We also work with the Moran Center, Connections for the Homeless, and Erie Family Health, to name just a few.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

**Mission and History**

Our mission is to advance educational justice in partnership with District 65. B&B envisions an Evanston in which every child is understood to be a valued and connected part of the community, where every school reflects this reality, and where every child is able to reach his or her full academic potential. B&B envisions an Evanston community that is actively committed to just and equitable outcomes for all its children.

B&B started in Evanston nearly 40 years ago when parents and school leaders at Orrington Elementary recognized a need for breakfast and decided to act. Through the years, D65 staff and Evanston community members partnered at multiple schools making sure children had access to a healthy meal through the B&B program. Faced with dwindling volunteer support in 2012, a decision was made not to cut the program but to reinvent it. In addition to the morning meal, B&B made a commitment to provide a daily academic boost from caring and supportive tutors. To sustain this new level of holistic supports, Books & Breakfast became an independent non-profit in July 2013.

**Organization and Board**

B&B has grown to 12 staff members, 40 paid NU tutors, and 400 community volunteers. Our board is made up of 10 Evanstonians with a broad range of experience. They provide fiduciary oversight and ensure that our efforts are always on mission. Board committees provide fundraising assistance, recruit volunteers, oversee HR & Financial, and offer strategic input on growth and expansion. Our staff and board all have deep ties to the Evanston community.

**Pivot for COVID**

The pandemic both tested and affirmed B&B's holistic approach. We are proud to report we successfully adjusted our programming locus to meet the needs of B&B students and families during the pandemic while staying on mission. We've learned we can grow more quickly than previously thought and are prepared to step up again to address the aftermath of the COVID-19 crisis over the long term.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

We have documented use of City grants for 2 year. Policies & procedures adhere to best practices. Yearly independent audit. We recently hired Mind Your Business accounting to support us and provide another layer of oversight.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

B&B uses qualitative and quantitative measures to gather feedback from students, parents, educators, tutors and volunteers. For example, we administer beginning- and end-of-year surveys with these groups and regularly use their feedback to improve our programming.

The most vivid example of evaluation-driven improvement is, of course, due to the pandemic. Qualitative data and anecdotal reports showed that B&B's program translated relatively well to a remote environment when the pandemic first hit in 2019-2020, but we spent that summer deepening our capabilities to provide the academic and social-emotional support needed by our students and their families. We worked closely with D65 to overcome barriers inhibiting our trained tutors from connecting online with their B&B students, created a new online program, and expanded our program exponentially as described elsewhere in this application.

Another example comes from parent-input via surveys, which drove home to B&B how vital our site directors were when referring families to health care, mental health providers, legal assistance, and other basic needs -- even before the pandemic. Because of this insight, B&B planned to launch a Parent & Family Advisory Board during the summer of 2020 to help inform programming and enhance our ability to meet the needs of B&B families more robustly. We had hired a part-time Parent & Community Engagement Specialist whose responsibilities included staffing this advisory board as well as ensuring relationships with community partners are preserved over time. The pandemic interrupted this plan and we decided to delay the project to focus on meeting urgent needs voiced by our B&B families instead. We will take up this project again over the summer of 2021 and hold the first meeting sometime in the coming fall.

Lastly, teacher surveys showed our initial monthly system of gathering their input about students was too cumbersome for them. We revised the system to evaluate progress over baseline for students at mid-term and across the year.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is**

## engaging people of color in decisions?

B&B has a total programming staff of 11:

### Case Managers

1. Executive Director (Kim Hammock, 8 yrs w/ B&B) is also serving as Dewey & Washington Site Director

Age: Late 40s

Gender: Female

Race: White

Pronouns: she/her/hers

B&B Tenure: 8 years

2. Director of Operations, Lincolnwood & Walker Site Director (Kyle Hanawalt)

Age: Mid 30s

Gender: Male

Race: White

Pronouns: he/him/his

B&B Tenure: 6 years

3. Director of Programming, Kingsley, Willard & Orrington Site Director (Tasha Triplett)

Age: Early 40s

Gender: Female

Race/Ethnicity: Black/Non-Hispanic

Pronouns: she/her/hers

B&B Tenure: 4 years

4. Director of Family & Community Engagement, Lincoln & Dawes Site Director (Cara Carothers)

Age: Late 40s

Gender: Female

Race/Ethnicity: Black, Native American/Indigenous, German and Irish descent

Pronouns: she/her/hers

B&B Tenure: 2 years, 3 months

5. Middle School Site Director (Michelle Foster Everly)

Age: Mid 20s

Gender: Female

Race: Multiracial (black & white)

Pronouns: she/her/hers

B&B Tenure: 2 years plus 2 years as a paid NU tutor

Assistant Site Directors were hired for emergency expansion in fall 2020 and are in their early-mid 20s:

6. Dewey & Washington (Kara Roseborough, female, black)

7. Lincolnwood & Walker (Miranda Lonzo, female, Latinx)

8. Kingsley, Willard & Orrington (Mauricio Sosa, male, Latinx)

9. Dawes (Erika Castillo, female, Latinx)

10. Dawes (Caroline Scott, female, white)

11. Middle School (Kevie Yu, female Asian American)

All staff have strong connections to Evanston, backgrounds in education, and profound commitment to B&B's mission of advancing racial equity and justice (see bios). Staff range in age from 23-49 years old, 9 of 11 are female, and consists of 3 individuals who identify as Black, 3 as Latinx, 1 as Mutli-racial (Black and white), 1 as Asian American and 3 as white.

City funding will directly fuel our capacity to meet demand for growth to serve additional marginalized children and their families. Rapid online expansion is critical to support social-emotional and academic needs during remote learning. Once schools re-open, in-person growth will be needed to address the long-term impact of the pandemic on children from marginalized communities.

Specifically, we seek City funds to go toward salaries for: a Spanish speaking case manager to support an increasing number of English Language Learners; a new site director for Dewey (our largest site), so the executive director may return to leadership and fundraising duties full time, and; our director of family and community engagement who will enhance our ability to refer families to Evanston's resources and follow up on their progress.

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS**

number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."

056878252

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

- Yes
- No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

IF "YES," ENTER "NA."

NA

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

For remote, we ensure families have D65 technology. In-person sites: Dewey, Lincolnwood, Kingsley, Lincoln Elementaries, and Haven, plus 3 more TBD summer 2021. Students walk, are driven, or arrive at school via carpools we arrange.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

Jennifer Cline

**Budget [top](#)**

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Funds (CDBG & MHB)	USD\$ 36,750.00	USD\$ 45,000.00	
Corporate	USD\$ 20,000.00	USD\$ 10,000.00	
PTAs	USD\$ 12,500.00	USD\$ 12,500.00	
Individuals	USD\$ 355,500.00	USD\$ 425,000.00	
Grants	USD\$ 61,000.00	USD\$ 85,000.00	
	USD\$ 0.00	USD\$ 0.00	
	USD\$ 0.00	USD\$ 0.00	
	USD\$ 0.00	USD\$ 0.00	
	USD\$ 0.00	USD\$ 0.00	
	USD\$ 0.00	USD\$ 0.00	
<b>Total</b>	<b>USD\$ 485,750.00</b>	<b>USD\$ 577,500.00</b>	<b>USD\$ 0.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
Professional Services	USD\$ 18,200.00	USD\$ 30,000.00	
Cradle to Career Membership	USD\$ 125.00	USD\$ 125.00	
Program Supplies	USD\$ 53,075.00	USD\$ 55,000.00	
Postage and Shipping	USD\$ 500.00	USD\$ 1,000.00	
Staff Training	USD\$ 4,000.00	USD\$ 4,000.00	
Marketing	USD\$ 2,500.00	USD\$ 5,000.00	
Insurance	USD\$ 7,003.00	USD\$ 7,000.00	
Salaries and Benefits	USD\$ 395,005.00	USD\$ 455,000.00	USD\$ 45,000.00
Occupancy	USD\$ 7,200.00	USD\$ 18,000.00	
Office Supplies and Materials	USD\$ 1,000.00	USD\$ 1,000.00	
<b>Total</b>	<b>USD\$ 488,608.00</b>	<b>USD\$ 576,125.00</b>	<b>USD\$ 45,000.00</b>

**Budget Narrative**

B&B is on a July 1 - June 30 fiscal year. We have projected our calendar year 2021 based on our current FY20 budget.

In response to the COVID-19 crisis, B&B engaged in emergency expansion in fall 2020, growing from 5 to 11 D65 schools. The increase in our budget from 2020 to 2021 reflects this needed response to the COVID-19 crisis and remote learning to meet the demand of our program from additional sites. B&B has received inquiries and requests from parents and school staff from numerous additional District 65 school sites to expand our in-person program when schools re-

open. In response to these requests, B&B seeks to accelerate the growth pattern established in our 5-Year Strategic Plan and add up to 3 new in-person sites next year.

We request \$45,000 in City funds to support our emergency online expansion during this school year and lay the foundation to open 3 new in-person sites next year. All City funds would go towards Salaries and Benefits for Case Managers. From Jan-Jun 2021, we would allocate \$5,000 toward each of 5 case managers, totalling \$25,000. From Jul-Dec 2021, City funds (\$15,000) would help pay our director of family and community engagement to flesh out a referral tracking system, launch a Parent and Family Advisory Board, and devise a system to ensure relationships with peer organizations remain strong over the long term. Lastly, City funds (\$5,000) would be allocated for salary for a bilingual case manager who is fluent in Spanish. This is vital as we seek to expand the number of TWI schools with in-person programs to support the growing number of English language learners in D65.

It is imperative we hire another site director to free the executive director return to full-time focus on leadership and development. City funding for existing programs is a critical piece of our expansion. It is essential that we grow responsibly even under the pressure of the pandemic, without jeopardizing the sustainability of our current schools. Helping us fund our current sites allows us to keep growing. If adequately funded, we can sustain our current sites with online programming and expand our services to 6 additional schools during remote learning. Moreover, we will be prepared to launch 3 additional in-person sites in January 2021 thereby supporting more Evanston students and families, all of whom are Evanston residents.

We are fortunate to have the financial support of many people in our local community. Individuals and foundations have largely sustained our budget and allowed it to grow from \$60,000 in 2013 to more than \$600,000 needed to run our program in the current school year. As we strive to meet the demand for new B&B sites within our community, we are committed to broadening our fundraising efforts. We do not currently receive any funding from the State of Illinois or any federal programs making funding from the City of Evanston even more critical.

## Program Outcomes [top](#)

### Program Outcomes

	Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
1	Students show increased social emotional readiness for the school day	75% of our total students show increased social emotional readiness for the school day based on end of school year surveys	187	135	322			0
2	Students and their families feels supported by and connected to B&B and their school communities in the midst of remote learning	# of times B&B staff contacted parents during remote learning	5,000	5,000	10,000			0
3	Students have the resources they need to engage in remote learning	# of individualized packages of books, academic supplies, and essential items delivered to B&B participants	350	400	750			0
4	Students participate in online academic and social-emotional support programs when school buildings are closed due to COVID-19	# of students who participated in B&B online sessions	250	120	370			0
5	Students complete their homework	# of homework assignments completed during the school year	2,500	2,500	5,000			0
	Students start the school day with a healthy breakfast	# of of meals served during the school year	0	3,000				
<b>Total</b>			<b>8,287</b>	<b>11,155</b>	<b>16,442</b>	<b>0</b>	<b>0</b>	<b>0</b>

### Program Line Item Expenditures

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Documents [top](#)

#### Documents Requested \*

REQUIRED FOR ALL EXTERNAL APPLICANTS. Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two

#### Required? Attached Documents \*



[B&B Draft Audited Financials](#)  
[B&B 990 2020-2021](#)

[Books & Breakfast Annual Report](#)  
[Books&Breakfast Strategic Plan](#)



[Books&Breakfast tax documentation letter](#)

years).

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

[B&B Non Discrimination Policy](#)

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.



[Brief Bios of B&B Case Managers](#)

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

Supplemental information relating to your program or agency, as applicable.

[B&B Letter of Support from D65](#)

[B&B Reading List](#)

Form used to document income of participants to establish eligibility.

HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Policies/procedures for case management process and case file documentation/maintenance.

[Books & Breakfast End-of-Year Survey](#)

[Books & Breakfast Student Plans](#)

[Books & Breakfast Student Evals -- Tutor Trackers](#)

[Fall teacher survey \(e-version\)](#)

[Fall teacher survey](#)

[B&B End of Year Teacher Survey](#)

[B&B End of Year Teacher Survey \(e-version\)](#)

[B&B Parent Consent Form](#)

[B&B Parent Registration Form](#)

[Tutor Input Form -- Daily](#)

[B&B Parent Need Survey Sample Page](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS.



[B&B Chart of Accounts](#)

Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

REQUIRED FOR ALL EXTERNAL APPLICANTS.



[B&B Statement of Revenues and](#)

[B&B 2021 Revs and Expense to Date](#)

Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).

Organizational commitment to equity, diversity and inclusion.

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[Books&Breakfast Current Operating Budget](#)

Board of Directors, including demographic information, professional affiliations and home

[Books&Breakfast Board of Directors](#)

address. If a regional organization with a local board of directors, attach listings of both boards.

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form.

[download template](#)



[B&B Conflict of Interest Disclosure 2021](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.

[download template](#)



[B&B Non-Duplication of Benefits 2021](#)

\* ZoomGrants™ is not responsible for the content of uploaded documents.

Application ID: 349908

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## Childcare Network of Evanston Learning Together

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 63,400.00** Requested

Submitted: 4/21/2021 1:55:24 PM  
(Pacific)

### Project Contact

Carol Teske  
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Tel: (847) 475-2661

### Additional Contacts

*none entered*

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### Executive Director

Carol Teske  
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## Application Questions [top](#)

### 1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?

CNE's Learning Together ("LT") program provides free mental health and other developmental therapeutic services and supports to Evanston children enrolled in full-day preschool programs where LT services are offered, which are programs serving primarily children from low- and moderate-income families.

The LT program currently partners with 6 local early childhood sites: 2 Head Start classrooms administered by CNE and operated by the McGaw YMCA in the Family Focus building, Swift Childcare Center (located in Skokie but serving many Evanston residents), the YMCA Children's Center, Robert Crown Center, Learning Bridge Early Education Center, and Reba Early Learning Center. Children are referred to the LT program when either a classroom teacher at one of these sites or a parent of a student identifies a need for support. If the parent consents, the case management relationship begins, and the child is assessed by one of the LT program therapists. Referrals do not come from outside social service agencies.

### 2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.

As described above, the LT program currently partners with 6 local early childhood centers to provide mental health and other therapeutic services to children and families who would likely be unable to access them otherwise. All these centers serve primarily low-income children whose families qualify for a childcare subsidy from the IDHS Child Care Assistance Program (CCAP). To be eligible for CCAP funding, a family's income must be less than 200% of the Federal Poverty Limit - for a single parent with two children, this translates to an annual income of less than \$43,920. In addition, although many of these children received free, in-home therapeutic services through the IDHS Early Intervention program (designed to serve children from 0-3 years old), there are far more limited services for children 3-5 years old. As a result, these children often enter an early learning program with no continuing support, and the family's income level leaves them unable to access costly outside therapies.

Although financial need is not a criterion for receiving LT services, recent demographic data from the LT program illustrates that the majority of the children served are non-White and come from families whose income is low to moderate (meaning less than 80% of the median income). By being intentional in choosing the sites through which to offer LT services, we can ensure that the majority of LT services are accessed by (1) families from low- to moderate-income households and (2) non-White children and their families.

### 3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?

The LT program strives to serve all children who are identified as in need of services. No children are turned away, and as a result, there is no waitlist for the program. Given the constraints of available funding and therapist time, however, during periods of high demand for services (often near the beginning of a school year when needs are first identified), children may have to wait longer to be seen by an LT therapist and/or spend less time with the therapist.

**4. Does demand fluctuate throughout the year? If so, please explain.**

Demand is typically higher in the fall near the beginning of the school year, when children's needs are first identified. Demand is generally lighter in the summer months.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

In 2020, LT supported 37 unduplicated individual children with LT services, 65% of whom are Black/non-Hispanic, 3% Black/Hispanic, 14% White/non-Hispanic, 5% White/Hispanic, 5% Asian, and 8% identified as being Multi-Racial. Of these children, 59% are from single-parent households that are primarily female-headed, and 57% identify as having children with disabilities or special needs. In addition, 86% of children served in 2020 are from families whose income is very low, low or moderate (based on the "median area household income" criteria), and only 14% of children served are from families whose income is not low/moderate.

Eligibility for LT services is based on an individual child's need for specific therapeutic interventions and not a child/family's socio-economic or demographic status. However, CNE is quite intentional in selecting those early childhood programs through which to offer LT services. By partnering with programs that serve primarily low- to moderate-income non-White children and families, we can maximize our reach to underserved populations and make sure LT services are targeted to populations where the need is most critical.

Across the 6 LT partner sites, case managers serve a total of 17 local early learning classrooms, with the potential to reach almost 200 students. In addition to the service plans set up for individual students with identified needs, case managers also consult with teachers to address specific classroom issues, and they provide mentoring and strategies to implement that can improve the overall classroom environment. They further meet with parents of children receiving services to offer additional support and strategies. All of these consultations will be recorded in the case management database (discussed in more detail later in this application) for data collection purposes.

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

60	Unduplicated people to be served in 2021
48	Unduplicated Evanston residents to be served in 2021
48	Unduplicated low/moderate income people to be served in 2021
37	Unduplicated people served in 2020
29	Unduplicated Evanston residents served in 2020
32	Unduplicated low/moderate income people served in 2020
25	Unduplicated low/moderate income Evanston residents served in 2020
279.00	<b>TOTAL</b>

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

4 total participants were enrolled as of January 1, 2021, 3 of whom are Evanston residents. Since that date, 21 Evanston residents have enrolled (out of 25 total). We expect to enroll 24 more by December 31, 2021.

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

The Learning Together team is composed of highly-trained expert consultants in mental health, speech-language, and occupational therapy. This team is coordinated and supervised by a team of 2 case managers, both of whom also serve as LT therapists in direct service capacities. Brief biographies of the team members are uploaded with this application.

Lead Case Manager: Chava Alpert, LCSW (early 50s, female, White). Chava has 20 years of experience working with young children and families as a mental health consultant and psychotherapist. She holds a master's degree in social work from Yeshiva University and advanced training in Social Thinking and TheraPlay. Chava stays in ongoing contact with the other LT therapists regarding all administrative and clinical work. As an LT therapist herself, she has over 15 years of experience working with young children and families and 10+ years as an LT therapist.

Case Manager: Aviva Levine Jacobs, PsyD (late 30s, female, White). Aviva holds a PsyD in Clinical Psychology and has over 10 years of experience working with young children and families. She is in her 2nd year working with the LT program.

Speech-Language Therapist: Toby Meyer, Ph.D. CCC-SLP (mid-50s, female, White). LT contracts with a speech-language therapist with a doctorate in speech/language pathology and a master's degree in special education with over 30 years of experience treating young children and families as well as 7 years as an LT consultant.

Occupational Therapist: Linnea Belder OTRL (mid-30s, female, White). LT also contracts with a pediatric occupational therapist that has supported children and families in a variety of settings over the past 10 years. She has provided occupational therapy services to support children and families through in-home services for Early Intervention, worked closely with families in a DIR Floortime clinic setting, and in elementary and middle schools. For the LT Program, she provides virtual support for teachers, staff, and families regarding motor skills and

sensory processing development, strategies for developing self-regulation, and support for independent participation in daily routines and school activities.

Additional biographical, licensing, and accreditation information is uploaded with this application. We are not anticipating hiring additional staff at this time.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

There are currently 2 case managers - they are consultants to CNE's LT program. Although their caseloads fluctuate, the average is approximately 20 children at any one time. Over the course of the year, they estimate they serve between 60-80 children.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

There are a variety of methods that case managers (and other LT service providers) use when working with participants. When a child is first identified with a potential need, case managers may review any existing assessments, which may include (1) an ASQ (Ages & Stages Questionnaire) completed by the childcare center and the child's parents, (2) an Individual Family Service Plan (IFSP) from the local Early Intervention agency, and/or (3) an Individual Education Plan (IEP) from the local school district. They may then conduct their own clinical observation and assessment of the child and determine the need for any additional developmental screenings.

LT case managers and service providers aim to support young children's successful participation in an early learning environment in a developmentally appropriate way. This crosses many domains - physical development (fine and gross motor skills), social-emotional development (emotional regulation, social interactions), and language/speech development. They take a strengths-based approach in working with children, all the while using a trauma-informed lens. The vast majority of the children served in the LT partner sites come from low- to moderate-income homes, and there are many who have experienced or witnessed some form of trauma in the home or in the wider community, which can manifest itself through classroom behavior. Addressing these behaviors in early childhood can help lead to more positive outcomes for the child and family. LT case managers and service providers also consult closely with classroom teachers and parents to inform goal-setting for children.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

All of the Learning Together consultants (current case managers and service providers) are licensed professionals in their relevant fields: social work, speech/language pathology, and occupational therapy. They are all required to complete a certain number of training hours for initial certification, and annually to maintain their licensure. These ongoing requirements could include training in cultural competency, ethics, and sexual harassment, just to name a few. CNE does not provide the LT consultants with training to maintain their licensure. However, when CNE does provide staff training in an area relevant to their work and/or their licensure, the consultants are invited to attend; recently, CPR training was offered to consultants. CNE will provide all LT consultants (case managers and service providers) with training on the new case management database system that is currently under development for use with the LT program.

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

A successful case management relationship in the early childhood context involves strong relationships and collaboration. LT consultants work with children ages 2-5 and families to support their success in an early learning environment. The length of their enrollment varies depending on the need, but all children age out of the program when they begin kindergarten.

When a case management relationship is established, a variety of players come together to support the relationship. One component is the direct contact between the case manager/service provider and the child. Depending on the content of the individual service plan, this could occur weekly or bi-weekly, and be done in the classroom or the child may be pulled out for services.

Another important component of the case management relationship is the regular check-ins that take place for each child with a service plan. These meetings would typically occur after an LT service provider has in-person contact with a child, and would involve the case manager as well as whatever other parties are supporting the child at that time - it could be the parents, teachers, other services providers, center directors, etc. It would depend on the child's needs and the status of the service plan at the time.

There are a couple of additional components that support the overall LT program. Each month, case managers conduct a site meeting with one of the LT partner sites, which involves any relevant service providers and classroom teachers to assess (1) the progress of those children with a service plan towards their identified goals, as well as (2) teacher and site needs with respect to the LT children at that site. In addition, the members of the LT team meet monthly to coordinate services and assess children's progress.

Client engagement is typically measured by the child's continued attendance at the site, continued participation in the LT program, and developmental progress over the course of their participation. If a child or family is not engaging in the services, the case manager would reach out to the parent to offer support from time to time. The hope would be that by maintaining and cultivating the relationship, the door could be left open for participation in services at a future time. Parents are never refused services, even if at some time they choose to opt-out of the LT program.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

When a family enrolls their child at any of the 6 LT partner sites, they are asked to sign an "Acknowledgement of Services" form, which makes them aware that services may be offered to them through the Learning Together program, which may include clinical speech screenings by the programs speech/language pathologist.

When a classroom teacher or parent identifies a child's potential need, the center director makes a referral to the LT program by providing

the child's parent with a consent form as well as a family information (intake) form. If/when the parents complete these forms, the center director forwards them to the CNE staffer who oversees the LT program, as well as that center's dedicated case manager. No other family documents (i.e., income verification, etc.) are required to be provided at intake or to qualify for services. No additional documents are required as part of the service plan, although any prior assessments of a child or IFSP/IEP (Individual Family Service Plan/Individual Education Plan) would be helpful in developing the child's plan.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

When a child has been identified and a parent has consented to the child receiving LT services, they will meet with the case manager to develop a service plan for the child. The typical components of the service plan would include (1) an identification of the services to be provided, (2) an identification of the service providers who will be engaged with the child (mental health, speech, occupational therapy, depending on the need), (3) the time/place the services are to be provided, (4) a plan for family engagement/relationship building (including meeting with the family to gather additional information about the child and their functioning at home and at school), (5) specific goals and outcomes for the child, (6) case manager and service provider case notes, (7) resources needed to help progress towards goals, and (8) any outside referrals made for the child.

The service plan will involve work in 3 areas: work with the child, parent(s), and teachers. The case manager and/or service provider will include case notes for work with each of those constituencies on behalf of the child. All case notes and service plan information will be tracked and recorded in a new database system that will be implemented for the LT program (a new module in the ChildPlus system - discussed in further detail in response to Question 17 below). Progress towards goals and outcomes is tracked through clinical observation by the case manager and/or service provider, and will also rely on parent and teacher input (for times when the case manager/service provider is not in the classroom). These will be reviewed at the regular case management meetings described above.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

Service plans reviewed and revised quarterly. Case managers and service providers enter progress notes in the database system regularly after each client contact/meeting.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

"Clients" of the Learning Together program are preschoolers, ages 2-5; they age out of the program when they enter kindergarten. Although LT services were paused during the beginning of COVID when early learning centers were closed, case managers and service providers have largely resumed seeing children on-site and in person. Depending on the needs of the individual child and the dynamics of the classroom environment, the LT case manager and/or service provider and the child (the "client") meet regularly (typically weekly) either in the classroom, or one-on-one out of the classroom. These contacts may or may not involve a classroom teacher. LT staff also rely on input from classroom teachers to assist with ongoing monitoring, since the teachers are in the classrooms daily with children.

A core component of the LT program is building the trusting relationships with children, parents, and teachers that can best support the child in reaching their developmental goals. These relationships are cultivated continually throughout the case management relationship with thoughtful communication and attention to the specific needs of each child. "Average progression" is more difficult to determine. Time is invested at the beginning of the relationship to establish trust among all parties. The progression of each child's development is unique, and may alternate between big leaps forward and times of regression. All the while, however, the goal remains to give children and families the support they need to have a successful and enriching early childhood experience to prepare them for school success.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

CNE currently uses a database program called ChildPlus to manage data for children in our Head Start and Early Head Start programming. We are in the process of setting up an additional module within ChildPlus through which case managers and service providers can record and track data relating to LT clients. Each LT case manager and service provider will have access to this online system, where they can (1) upload service plans for children identified for LT services, (2) track progress towards goals identified in the service plan, (3) maintain confidential child and family information (including consent forms, family information forms, and any other relevant documents), (4) record case notes, (5) track parent and teacher meetings, and (6) track resources offered and referrals made.

This module is currently being finalized, and therefore no screenshots are ready to be shared at this time. We will be happy to provide them when the module is complete. All of the LT case managers and service providers will be trained on the new module, as it represents a shift in how LT program data is currently collected and tracked.

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

When children meet their service plan goals, they generally stop seeing their LT therapist(s), but most remain active on the LT caseload so that the case manager and/or service provider can continue to monitor progress and provide support through the end of the child's time at the center. Monitoring also continues at LT team and partner site meetings to make sure that developmental gains made by children receiving LT services remain solid.

As indicated in an earlier response, early childhood development often ebbs and flows, so although there may be some period of time where a child seems to be adjusting well to the environment and may not regularly be meeting with an LT therapist, the therapists are still checking in with teachers and families and are available to resume support in the event that something occurs (either at school or at home) which prompts the need for further LT support for a child.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the**

**barriers to receiving those services?**

The LT services that children most often need to achieve their service plan goals in the early childhood context are unique to each child, but generally support the development of a variety of skills: emotional regulation, speech (particularly with articulation and processing), social skills (interacting and playing with peers), and gross and fine motor skills. Efforts are geared towards making sure children have the supports they need to make a successful transition from early childhood learning to kindergarten.

As indicated previously, LT services are provided at no cost to families, so there are no economic barriers. There are a few barriers that we believe families do experience to accessing these services. First, many parents are hesitant (at least initially) to have their child receive LT services. A strong, trusting relationship between a childcare center and a family can help to overcome this barrier. Another barrier can be the willingness of a very young child (between the ages of 2-5) to engage with the therapist. Again, taking the time to develop this foundational relationship helps to overcome this barrier. Successful provision of services to a young child also requires considerable support from parents, teachers and partner site administrators, all of whom come together to help meet the child's needs. If those parties aren't working together effectively, it can be a barrier to receiving services. Fortunately, because the LT program has been working with many of its current partner sites and teachers for some time, in many cases there are effective, established working relationships that can be leveraged to help support children in need of services.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

LT therapists have a variety of referral sources for the children they serve, both within CNE's organization and out to other agencies and therapists. Within CNE, children can be referred to our Head Start/Early Head Start Home Visiting program, but if the child is already in full-day programming, time constraints may preclude this option for some families. Outside of CNE, LT therapists have referred children for services to (1) local school districts, including Evanston/Skokie School District 65, (2) outside mental health, speech, occupational and physical therapists, and (3) pediatricians and dentists, including those accepting Medicaid. To help support the family, referrals may also be made to resources for legal or financial support for low-income families. Tracking of referrals is done by therapists individually. Right now, there is a privately shared online document where LT therapists may enter intake information, notes from visits, and referral information. This system is currently being transitioned to the online ChildPlus system (described in a previous response), and referrals and other LT information will be tracked through that system going forward.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

CNE has contracts with each of the early childhood sites where LT services are provided, specifying each party's responsibilities with respect to the LT program, and acknowledging that all parties have an active, collaborative role to play in supporting children identified for LT services. In addition, there are separate agreements/MOUs with local school districts, the Evanston Early Childhood Council, Child and Family Connections (Early Intervention services), and the Evanston Cradle to Career Initiative, all designed to collaboratively support the LT program by providing a variety of ways to connect families to necessary services, resources, and referrals.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

Since 1970, CNE has been linking local families to high-quality early education, childcare, and other community resources to help promote school readiness and family stability. As a Head Start/Early Head Start grantee, CNE oversees a variety of programming: home visiting, 1 family childcare home, 2 Early Head Start classrooms, and 3 Head Start classrooms, in total serving over 100 children. In addition, CNE is the administrator of (1) a grant from the Illinois State Board of Education to provide preschool services at 5 local early childhood centers to 118 children, and (2) funds from the IDHS Child Care Assistance Program to provide childcare subsidies to 79 children (currently, and the number is growing as children return to in-person instruction).

CNE is led by an Executive Director, who is supported by a highly qualified leadership team, including a Director of Programs/Head Start and a Fiscal Officer. They in turn are supported by teams of Intake Specialists, Home Visitors (Parent Educators), and Family Support Specialists.

The Board is currently composed of 13 members, with expertise in law, accounting, real estate, social services, government, and early childhood education. A parent from one of the families in our programming also attends Board meetings as a liaison to ensure constituents' voices influence policies. The Board oversees the execution of the strategic plan, supervises and develops executive leadership, ensures strong succession plans for staff and board, oversees compliance with federal and state regulations, reviews financial statements, and participates in annual program and financial planning. There are also active Executive, Finance, Governance, and Human Resources committees of the Board.

CNE was in the midst of preparing an updated Strategic Plan when COVID hit in early 2020, and those efforts were sidelined as we focused on helping families meet immediate, urgent needs brought about by the pandemic. Strategic planning activities are resuming right now, but the plan has yet to be finalized. The current draft of the plan is uploaded with this application. The draft Strategic Plan will be the main focus for CNE's Board of Directors at their April meeting.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

As a grantee of federal funds, CNE fiscal controls are tested annually as part of the single audit process, as required by Federal Uniform Guidance. The Finance Committee of the Board, chaired by an accountant, ensures financial compliance and integrity.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

Currently, there is no formal mechanism CNE uses to gather participant feedback (i.e. no parent/teacher survey, etc.). Anecdotal feedback is given from time to time either to teachers or administrators at the site, or perhaps directly to the case manager or service provider. Feedback may come from teachers and/or parents. At regular LT team meetings, feedback received may be discussed and used to inform improvements in services and service delivery. We hope that with the implementation of the new data management system, there will be a more consistent way to capture, review, and incorporate program feedback.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

The CNE team is made up of 23 women employed as staff or consultants, 14 of whom (61%) are women of color. They range in tenure from a few months to over 10 years.

The executive leadership team of 3 consists of the Executive Director, Director of Programs/Head Start, and Fiscal Officer. 2 of the 3 members of the executive leadership team (67%) are women of color. The staff as a group maintains a very collaborative relationship, and there are multiple avenues available for involving people of color in the decision-making process. All supervisors conduct regular reflective supervision meetings with individual staff members, there are weekly all-staff Zoom meetings, regular team meetings, and annual "check-ins" for each staff member with the Executive Director.

Over the last few months, CNE staff has begun to reflect more deeply and engage more personally on issues of race and equity. Over the course of 8 weeks, staff members participated in a required set of facilitated sessions with 2 different diversity, equity, and inclusion consultants (one of whom is CNE's Education Consultant). Some CNE staff members also participate in an optional bi-weekly book club to discuss "Courageous Conversations About Race." Through activities like these, we hope to be able to better understand, represent and incorporate the diverse voices on our staff and throughout our programming into organizational practice. CNE's Equity Committee continues to investigate opportunities to further this work.

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

859013336

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

- Yes
- No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

*IF "YES," ENTER "NA."*

One step to the front door, but 2 accessible side entrances and 2 accessible bathrooms on the 1st floor. Client intake, family programming and family night activities (when in-person) all occur on the 1st floor.

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

CNE's office is at 1335 Dodge in Evanston and accessible from 3 bus routes (93, 206 and 250). There is street parking available and a bike lane on Dodge, making accessibility by bike easier. Staff also meets clients in their homes or other locations.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

Carol Teske, Executive Director

**Budget** [top](#)

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Funding Request	USD\$ 47,025.00	USD\$ 63,400.00	
Social Emotional Learning Grant	USD\$ 73,125.00	USD\$ 71,781.00	
<b>Total</b>	<b>USD\$ 120,150.00</b>	<b>USD\$ 135,181.00</b>	<b>USD\$ 0.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
Personnel and Fringe	USD\$ 11,508.00	USD\$ 10,861.00	USD\$ 5,094.00
Office Supplies	USD\$ 268.00	USD\$ 213.00	USD\$ 100.00
Occupancy (Rent, Phone, Utilities)	USD\$ 1,886.00	USD\$ 5,156.00	USD\$ 2,418.00
Contractual (Mental Health, OT, Speech Consultants)	USD\$ 103,493.00	USD\$ 117,537.00	USD\$ 55,125.00
Contractual - Other (IT, HR, Operations)	USD\$ 2,995.00	USD\$ 1,414.00	USD\$ 663.00
<b>Total</b>	<b>USD\$ 120,150.00</b>	<b>USD\$ 135,181.00</b>	<b>USD\$ 63,400.00</b>

**Budget Narrative**

Childcare Network of Evanston's fiscal year is July 1st through June 30th. The Learning Together Program budget for calendar year

2021 is \$135,181 with \$117,537 (87% of the total budget) for mental health, speech/language, and occupational therapy consultants who work with children with special needs. The budget also includes \$10,861 (8%) for CNE staff who work to provide support to the program. The remaining costs of \$6,783 (5%) are for office supplies, occupancy, and other administrative expenses.

Funding for the program is provided by the City of Evanston (47%) and a Social Emotional Learning grant (53%) secured by CNE. The funding for the Social Emotional Learning grant is not dependent on federal or state revenue.

Of the \$63,400 funding request from the City of Evanston, \$55,125 (87%) is for mental health, speech/language, and occupational therapy consultants who work closely with the children with special needs. The requested budget amount is based on a total of 70 therapist hours per month (cumulative hours for all 4 therapists currently providing LT services), at their rate of \$75/hour for an estimated 10.5 months of the year:  $70 \times \$75 \times 10.5 = \$55,125$ . This represents an increase in projected therapist hours over the previous year's grant, which can be primarily attributed to 3 factors: (1) an anticipated increase in the number of children being identified as in need of services after COVID, (2) additional therapist hours required to learn and record case documentation in a newly-developed case management database system, and (3) the addition of one more child care center to the LT program – the Robert Crown Community Center Child Care Program, which has a 2-year old program as well as "Creative Play Preschool" for ages 3-5.

Of the remaining amount sought from the City of Evanston, \$5,094 (8%) is for personnel costs to manage the program and \$3,181 (5%) is for supplies, occupancy, and other administrative expenses. The MHB contract would fund 0.058 FTE: 0.029 FTE of a Director of Programs/Head Start and 0.029 FTE of operations and accounting support staff. All positions are currently filled. Other public funds awarded to Childcare Network of Evanston in fiscal year 2021 total \$3,005,938. The sources of these public funds are: \$1,673,220 Head Start/Early Head Start (federal), \$399,718 Illinois State Board of Education Preschool for All (State of IL), and \$933,000 Department of Human Services Child Care Assistance Program (State of Illinois).

**Program Outcomes** [top](#)

**Program Outcomes**

	Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
1	85% of participating children will make progress towards their goals.	A service plan is developed for each child receiving services, which include therapeutic goals with progress towards those goals.	30	30	60			0
2	85% of participating children will remain enrolled throughout the school year.	Site Directors and Case Managers will provide data for children receiving LT services who are unable to remain in care.	30	30	60			0
3	75% of teachers will implement tools and strategies on each child's service plan.	Case managers and service providers will share tips and techniques per the child's service plan. Providers will monitor progress through classroom observations of the child and teacher, parent feedback, and clinical conversations.	30	30	60			0
4					0			0
5					0			0
<b>Total</b>			<b>90</b>	<b>90</b>	<b>180</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Program Line Item Expenditures**

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0

11						\$ 0
12						\$ 0
13						\$ 0
14						\$ 0
15						\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Documents [top](#)

#### Documents Requested \*

REQUIRED FOR ALL EXTERNAL APPLICANTS. Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

Supplemental information relating to your program or agency, as applicable.

Form used to document income of participants to establish eligibility.

HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Required?



#### Attached Documents \*

[CNE FY20 Audited Financial Statement/Single Audit](#)

[CNE Form 990 - Federal and IL](#)

[FY2020 Annual Report](#)

[CNE Draft Strategic Plan](#)

[501\(c\)\(3\) letter](#)

[Biographies of Key Staff - CNE and LT 2021](#)

Policies/procedures for case management process and case file documentation/maintenance.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.



[Chart of Accounts](#)

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).



[CNE FY20 Statement of Operating Revenues and Expenditures](#)

Organizational commitment to equity, diversity and inclusion.

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[CNE FY21 Budget](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form. [download template](#)



[CNE Conflict of Interest Form](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form. [download template](#)



[CNE Duplication of Benefits Form](#)

\* ZoomGrants™ is not responsible for the content of uploaded documents.

Application ID: 349057

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## Family Focus, Inc. Case Management

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 125,000.00** Requested

Submitted: 4/21/2021 2:18:16 PM (Pacific)

### Project Contact

Mark Brown

[mark.brown@family-focus.org](mailto:mark.brown@family-focus.org)

Tel: 312-421-5200

### Additional Contacts

*none entered*

### Family Focus, Inc.

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### President and CEO

Dara Munson

[Dara.munson@Family-focus.org](mailto:Dara.munson@Family-focus.org)

## Application Questions [top](#)

### **1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?**

We have four programs to serve the Evanston community. Our afterschool programming serves children in the 3rd through 8th grade, after-school activities are offered at the center Monday through during the critical hours of 3 p.m. – 6 p.m.; the time when a lack of constructive activity and supervision can lead to risk-taking behavior. Services continue on school holidays, and for seven weeks during the summer ensuring youth have enriching activities accessible in their free time. Programs focus on STEM (Science, Technology, Engineering and Math), literacy through creative writing, tutoring, visual and performing arts, character development, life skills training, and social-emotional growth.

The Early Childhood Home Visiting program is available to families with children ages birth to three. Using the Parents as Teachers (PAT) curriculum, the program aims to positively impact early childhood development, promote literacy, and nurture healthy parent-child relationships during the critical years in the comfort of each family's own home. Home visiting addresses critical years of social, emotional, and cognitive development with the parents in the home. Home visiting staff meet with families in the environment where they spend most of their time and track progress along developmental domains to ensure that children are meeting critical developmental milestones.

The Family Advocacy Center is funded by the Illinois Department of Children and Family Services (DCFS). The FAC provides supportive services for DCFS-involved families in our community. Staff provide parenting classes and one-on-one support from a staff member to parents who have been reported to DCFS for potential abuse/neglect. Services include parenting classes and coaching, supervised parental visits, access to community resources, court advocacy, home visits, and more.

Grandparents Raising Grandchildren is a support group for grandparents raising their grandchildren that provides community and educational support for challenges like advocating for parental rights.

Each program has an intake process that gathers information from participants to determine needs and goals.

We also provide a food pantry and clothes closet called The Giving Storeroom open to our participants and all members of the community in need.

(Will need to get percentage of referrals) We receive referrals from a variety of sources. For the afterschool and summer camp programs we receive referrals from school personnel including teachers and social workers. Families are also referred by the City's Youth and Adult division. In addition to an extensive outreach and recruitment plan, our early childhood home visiting program receives referrals from partner agencies such as Curt's Café, WIC and CEDA and hospitals. Our Family Advocacy center receives the majority of its referrals from Department of Children and Family Services (DCFS). There is a great deal of cross referrals between programs.

**2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.**

Because of our location in the 5th Ward and the services we provide the majority of our participants are African American and Latinx. By providing a continuum of services with early childhood home visiting, afterschool care with academic support and cultural enrichment for 8-14 year olds, parent education, family advocacy and grandparent support, we make our families stronger and provide resources to so they build social capital and achieve upward economic mobility through high-quality innovative programs and services, grounded in anti-racism and social justice, part of our mission. With support from the City we can enhance our case management capabilities to better serve our current population and expand our services to more underrepresented community members.

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

We do not turn eligible participants away. If we cannot accommodate them, we put them on our wait lists and find other resources that will sustain them until they can be enrolled in our programs. An inability to hire additional staff prevents us from serving more. In addition, we have had to decrease onsite numbers due to COVID protocols. We do maintain wait list. Currently across all programs we have 11 on our wait list.

**4. Does demand fluctuate throughout the year? If so, please explain.**

Before the pandemic demand was pretty consistent. However, the requests for food, clothing, technology assistance, rental assistance has increased over the past year.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

Early Childhood: Number of Birth - 3 Children Visited 113 Number of Parents Visited 94; Low-income Families are Low Income 100%; Black or African-American 46%; Latinx or Hispanic 30%; Number of Children needing early Intervention 8%. Afterschool/Summer Camp: Number of 3-5th Graders 54; Number of 6th-8th Graders 32; Low-Income Families 79%; Black or African-American 94%; Latinx or Hispanic 3%; Diverse Learners 22%. Family Advocacy Center (FAC): Number of Families enrolled for ongoing support 105; Families Referred by DCFS 88%; Families with Children in DCFS Placements 28%; Black or African-American 28% % of Families are Latinx or Hispanic 25%

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

258	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
258	Unduplicated Evanston residents to be served in 2021	
258	Unduplicated low/moderate income people to be served in 2021	
218	Unduplicated people served in 2020	
218	Unduplicated Evanston residents served in 2020	
218	Unduplicated low/moderate income people served in 2020	
218	Unduplicated low/moderate income Evanston residents served in 2020	
1,646.00	<b>TOTAL</b>	

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

There were 218 enrolled in case management for early childhood program and FAC. With case management coordinator we hope to add 30-40 more families from the afterschool and Grandparents raising grandkids program by December 31, 2021.

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

Currently, there are seven (7) staff members providing home visiting, afterschool, and advocacy services, and Of the seven, all are female; 4 Black; 3 Hispanics. The program manager has worked for the agency for 18 years and has an LCSW and an MSW. All others have worked for the agency between 1-5 years and have bachelor's degrees in social work, psychology, or child development. All staff have prior experience in case management in other social agencies Hiring a new staff will provide case management across all programs. It is to centralize case management and ensure all programs, including the afterschool/summer camp program and the grandparent support group, benefit from case

management. The new position will depend on City funding and allow us to serve more families holistically.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

Seven staff members are serving in a case manager role for two programs. For the home visiting program, the caseload averages 24. For the Family Advocacy Center, the average is 26.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

Case management (CM) services are offered to all families from birth to five, afterschool, FAC, home visiting, and afterschool programs at Family Focus. CM is integrated throughout case management engagement to meet each family's needs and is provided by Social Work, Family Advocates, or Home Visitors. CM includes identifying needs for services beyond the scope of any one program (court advocacy, housing, food, public aid, employment), sharing resources and referrals with families (both intra- and inter-agency), and supporting caregivers with connecting to the resources they need. Addressing families' needs for concrete resources often facilitates the initial engagement of caregivers and strengthens the relationship between staff and families. Given that most of our families are below the poverty level, basic needs often take priority.

Assessments are administered by the Case Manager assigned to provide direct services to each family. If caregivers are willing and able, they may complete some assessments independently during or between sessions. The assessment process is used to engage and educate caregivers. Many caregivers feel more comfortable responding to structured questionnaires rather than sharing sensitive and often painful information about their families in an unstructured interview format with someone they have just met. The use of a structured assessment protocol has been shown to support engagement by increasing caregivers' comfort levels. Results of structured assessments and a summary of caregiver's concerns from structured and unstructured assessment interviews and case manager observations of child-parent interactions are shared with families and incorporated into the service plan development.

The average treatment period for families in FFE is between six and eighteen months; we have found that re-evaluation at a rate of five to eight sessions has been extended to 10-12 sessions to establish a positive milieu with the family. Termination assessments and Completion of Services forms are completed for everyone who participates in the case management.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

Program staff participates in trainings that include job specific responsibilities, including an annual review of pertinent rules and procedures. In addition, employment specific training identified by program administration is provided as needed. Each staff member is required to have any annual training plan and schedule. The training plan is to include topic areas covered in the training program, the hours devoted to each area, calendar of training events, facilitators of training events, and any plans to coordinate or share training events with other staff and agencies.

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

The components of case management include the monitoring of family's services and the family's progress in those services. It is the regular evaluation and assessment of services in an effort to ensure that the family is receiving both the required and the recommended services that will assist with its stabilization. The average client is seen twice a month for approximately 1-2 hours with intermittent phone calls in between.

Client engagement can be measured by the amount of agency services/programs/events they participate in as well as via surveys and direct feedback reports and case management contact progress notes.

Should participants choose not to engage, Case managers will document their efforts and allow the client to his/her right to self-determination but also leave them with our information and the knowledge that should they change their mind, they can contact us then. Cases are usually monitored for the next 30-45 days prior to complete closure.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

At the initial intake assessment, case managers will interview the participant and collect information as well as documentation based on the requirement of the program. This information allows case managers to assist the family with creating a service plan that is specific to them and their goals and objectives. For programs that have income eligibility requirements, proof of income is requested.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

In a typical service plan, the family is asked to identify the primary areas of focus/need if self-referred by child welfare, the presenting issue of the family is discussed, and clearly defined goals and objectives will be created with clear and measurable timeless expectations. Also, specified are the persons responsible for said task and timelines. The typical outcomes would be "services completed successfully" but sometimes the outcomes are "participant declined to continue services" or client

disengaged, leaving no reason. Progress is tracked via internal data keeping as well as funder data base systems. Successes are measured via reports ran and data aggregation, personal statements from participants and service completion.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

Service plans are reviewed and revised every 6 months on average, but can be more frequently when goals are met and new ones need to be created. Progress note must be maintained weekly. Case managers will ensure that they keep all contacts with and on the behalf of the participants up to date.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

As with the development of any relationship, the better the rapport between parties, the better the working relationship of collaboration can flourish. Our case managers are empathetic to their clients and dedicated to ensuring that their clients needs are met. On the average, case management services can last for approximately 3-6 months or 3 years depending on the program. Case managers meet with their clients weekly to biweekly. These frequent meetings allow for the creation of a strong, trusting relationship.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

Case notes are documented in our Visit Tracker Data System.

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

Client's "graduate" or complete services when they have either successfully addressed presenting issues and have resolved them, completed a parenting class they were recommended or mandated to complete or completed a program that they enrolled in.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the barriers to receiving those services?**

Counseling, parenting, substance use, mentorship are the area's most often identified in service plans. Barriers to these services include, program expenses, locations in the participant's area, openings in programs as well as the current Pandemic that is COVID-19.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

Referrals are provided to our participants when they require a service that we do not provide internally or when the services that we provide are not a good fit for the client's needs. At Family Focus the services for outside referrals generally include Housing, Family therapy, and Substance use treatment.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

Yes, the agency has MOUs with other organizations. Some are formal in writing, and some are informal but attested to by all parties. These agreements assist in having ports of entry when referrals are needed and, we support each other in professional development and efforts and supportive services. Our Partnerships include: Cradle 2 Career; Infant Welfare Society; District 65; DCFS; Start Early; Bundled Blessings; CEDA & WIC.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

Family Focus was founded in Evanston, IL in 1976 by Bernice Weissbourd, a leading scholar, educator in child development, and the organizer of the Family Support movement. Her vision, to promote the well-being of children by supporting and strengthening families in and with their communities has been the mission of Family Focus for over 40 years.

Family Focus has an Administrative Office in the city of Chicago, with six additional service locations within the metro Chicago area.

After a year of negotiations, on January 1, 2021, Family Focus and Chicago Child Care Society (CCCS) agencies merged into one organization and maintained the name Family Focus.

Family Focus and CCCS joined a shared mission to provide early childhood education, youth development and family support services in under-resourced communities across northeast Illinois. Our newly merged Family Focus combines the strengths and expertise of agencies to offer one comprehensive continuum of services for the entire family that can reach a larger geographic footprint.

Family Focus' new mission is: Family Focus invests in strengthening families and their children in Chicago and NE Illinois, so they build social capital and achieve upward economic mobility through high-quality innovative programs and services, grounded in anti-racism and social justice.

In FY22, Family Focus will begin its cycle of strategic planning. The strategic plan will keep us on track and allow us to respond to change while remaining faithful to our mission and vision.

Dara Munson, previously the CEO of CCCS, will be the new President and CEO of Family Focus. ReaderLink Distribution Services President and CEO, Dennis Abboud, who is currently serving on the Family Focus board, will be the first Board Chairperson of the combined organization.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

Family Focus maintains a Finance Policy and Procedure Manual as approved by the board of directors, which includes parameters of responsibility, financial controls procedures, and procurement policies.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

For the afterschool program, students and parents are surveyed three times a year. We also have monthly parent meetings where there is an open exchange of information. The feedback is used to inform future programming. For example, the decision to do programming remotely or onsite was determined by feedback from parents and students.

A parent advisory group meets at least twice a year and represents FAC, early childhood, and youth development programs.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

The program is supervised by Family Focus Evanston Center Director, Colette Allen, who joined the organization in July 2015. An Evanstonian herself, Colette has worked in the nonprofit sector since 1984. She worked as a corporate major gift officer at the Museum of Science and Industry and as Midwest Director of Development for the Foundation of Fighting Blindness. Colette was also Executive Director of Literacy Volunteers of Atlanta and worked for the US Olympic Committee, managing community and media relations. Ms. Allen holds a Bachelor's of Art from Oberlin College, and a Master of Science in Elementary Education from Bank Street College of Education in New York. Colette was also a student at the the school of drama at Yale University.

Senior Program Coordinator, Joann Avery has a MS in Human Services and more than 35 years of experience working with youth at Family Focus. Ronnie Cannon is a part-time instructor for the middle school class. He is a graduate of Claflin University with a major in math and computer science. We also have volunteer Instructors provided by EvanSTEM. We expect that a ration staff-to-student of 1:30-35 with dedicated volunteers, the ratio will always be lower.

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

09-680-1998

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

Yes

No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

*IF "YES," ENTER "NA."*

N/A

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

2010 Dewey Ave., Evanston, IL 60201 - Participants receive Bus Service transportation from school.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this**

application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.

True

**Budget** [top](#)

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Funding Request	USD\$ 59,600.00	USD\$ 0.00	USD\$ 0.00
City of Evanston - Arts Council	USD\$ 0.00	USD\$ 1,500.00	USD\$ 1,500.00
Justice Advisory Council	USD\$ 0.00	USD\$ 100,000.00	USD\$ 100,000.00
Dept. of Family Support Services	USD\$ 163,552.00	USD\$ 156,628.00	USD\$ 156,628.00
IL State Board of Education	USD\$ 416,157.00	USD\$ 410,785.00	USD\$ 410,785.00
Dept. of Aging	USD\$ 2,250.00	USD\$ 2,250.00	USD\$ 0.00
Foundation Awards	USD\$ 31,980.00	USD\$ 30,000.00	USD\$ 22,500.00
Tenant Rentals	USD\$ 217,000.00	USD\$ 187,000.00	USD\$ 100,000.00
Individual Contributions	USD\$ 17,500.00	USD\$ 15,000.00	USD\$ 0.00
Program Fees	USD\$ 6,200.00	USD\$ 5,000.00	USD\$ 0.00
<b>Total</b>	<b>USD\$ 914,239.00</b>	<b>USD\$ 908,163.00</b>	<b>USD\$ 791,413.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
Salaries & Benefits	USD\$ 715,333.00	USD\$ 801,868.00	USD\$ 110,100.00
Audit	USD\$ 4,186.00	USD\$ 3,177.00	USD\$ 705.00
Insurance	USD\$ 7,038.00	USD\$ 10,831.00	USD\$ 1,050.00
Occupancy	USD\$ 128,335.00	USD\$ 100,935.00	USD\$ 6,000.00
Transportation	USD\$ 9,335.00	USD\$ 4,329.00	USD\$ 500.00
Telephone/Internet	USD\$ 16,308.00	USD\$ 26,522.00	USD\$ 1,800.00
Supplies	USD\$ 56,358.00	USD\$ 32,820.00	USD\$ 2,620.00
Printing & Postage	USD\$ 2,066.00	USD\$ 1,304.00	USD\$ 200.00
Equipment Maintenance	USD\$ 1,500.00	USD\$ 12,722.00	USD\$ 1,025.00
Training & Development	USD\$ 7,519.00	USD\$ 4,069.00	USD\$ 1,000.00
Professional Services	USD\$ 7,911.00	USD\$ 6,891.00	USD\$ 0.00
Subscriptions & Dues	USD\$ 3,093.00	USD\$ 2,870.00	
Special Events / Participant Assistance	USD\$ 7,872.00	USD\$ 14,500.00	
<b>Total</b>	<b>USD\$ 966,854.00</b>	<b>USD\$ 1,022,838.00</b>	<b>USD\$ 125,000.00</b>

**Program Outcomes** [top](#)

**Program Outcomes**

	<b>Outcome</b>	<b>Indicator (How was success measured?)</b>	<b>Goal # (G): Jan-June</b>	<b>G: July-Dec</b>	<b>Goal Total</b>	<b>Actual # (A): Jan-June</b>	<b>A: Jul-Dec</b>	<b>Actual Total</b>
1	100% of participants will have services directly provided by program staff or be referred for community services as needed per the assessment.	100% of program participants will receive a comprehensive assessment to determine participant and family needs.	100	115	215			0
2	100% of all successfully discharged participants will have aftercare plans established to help ensure the family will maintain the gains made during program participation.	Satisfaction surveys are completed by the participant each quarter as part of the quarterly reporting process.	110	110	220			0
3	Increase in positive behavior amongst participants and	75% of participants will improve their attitudes about school by	100	115	215			0

	attitudes about school and school activities.	participating in school plus program activities and reducing school discipline reports.					
4				0			0
5				0			0
<b>Total</b>			<b>310</b>	<b>340</b>	<b>650</b>	<b>0</b>	<b>0</b>

### Program Line Item Expenditures

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

Documents [top](#)

Documents Requested \*

Required? Attached Documents \*

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.



[2020 Audited Financials](#)  
[990 Form](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).



[501 C 3](#)

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.



[Qualifications of Key Staff](#)

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

Supplemental information relating to your program or agency, as applicable.

Form used to document income of participants to establish eligibility.

HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Policies/procedures for case management process and case file documentation/maintenance.

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.



[Chart of Accounts](#)

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).



[Statement of Operating Revenues](#)

Organizational commitment to equity, diversity and inclusion.

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[Agency Operating Budget](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form.



[Conflict of Interest](#)

[download template](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.



[Duplication of Benefits Disclosure Form](#)

[Duplication of Benefits](#)

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\* ZoomGrants™ is not responsible for the content of uploaded documents.

Application ID: 350680

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## Housing Authority of Cook County Case management for senior buildings

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 70,000.00** Requested

Submitted: 4/21/2021 2:35:13 PM (Pacific)

### Project Contact

Emily Orenstein  
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Tel: 3125424799

### Additional Contacts

*none entered*

### Housing Authority of Cook County

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United States

### Executive Director

Richard Monocchio  
[rmonocchio@thehacc.org](mailto:rmonocchio@thehacc.org)

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Fax  
Web

## Application Questions [top](#)

**1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?**

We offer case management services to public housing residents at the Jane R. Perlman Apartments and the Victor A. Walchirk Apartments in Evanston. Residents of these properties must be over the age of 55 or persons with disabilities, and have household incomes below 60% of the local Area Median Income (AMI). Waitlists for housing at the properties open when capacity is available, and all who are eligible may apply.

**2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.**

As detailed in questions 1 and 5, the resident population of the HACC senior buildings consists entirely of low-income seniors and people with disabilities, the majority of whom are also people of color (primarily Black/African-American residents). Residents of Perlman and Walchirk often have behavioral health issues that prevent them from accessing the resources they need to thrive. Thresholds staff engage residents in the buildings regularly with biweekly site visits and office hours for a combined approximately 30 hours per month. Given the complex behavioral needs of many residents, however, this level of service is not sufficient to establish a relationship with many residents who would benefit tremendously from case management services. While current part-time staff members do work on building familiarity rapport with residents on the building who do not currently accept services, without a more consistent presence these residents will not receive the maximum benefit from having case managers onsite.

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

All residents of Perlman and Walchirk are eligible to meet with the Thresholds staff during service hours. The primary barrier to reaching more residents is that the process of building up trust with each resident is time-intensive. Many residents show some interest in receiving services, but need a full-time staff member would also be able to work more closely with the property managers at the buildings to identify individual residents' needs and reach out to individuals who might not be forthcoming about their needs.

**4. Does demand fluctuate throughout the year? If so, please explain.**

As we are a housing provider, we work from a set client base or residents, so demand for services does not generally

fluctuate, with the obvious exception of the COVID-19 pandemic, which brought a greater need for many services.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

All residents are low income, and most residents are very low income (defined as 50% of less AMI). Over half of the resident population at Perlman and Walchirk are people of color: 60.8% of residents identify as Black/African American, an additional 5% identify as Asian or Pacific Islander, and 2.5% identify as Hispanic/Latinx of any race. 71.8% of residents identify as having one or more disabilities; the overall breakdown is 56.3% elderly (reporting one or more disabilities), 27.6% elderly (no disability reported), and 16.1% nonelderly disabled. 55.8% residents are female and 44.2% are male. Most residents are individuals living alone.

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

52	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
52	Unduplicated Evanston residents to be served in 2021	
52	Unduplicated low/moderate income people to be served in 2021	
26	Unduplicated people served in 2020	
26	Unduplicated Evanston residents served in 2020	
26	Unduplicated low/moderate income people served in 2020	
26	Unduplicated low/moderate income Evanston residents served in 2020	
260.00	<b>TOTAL</b>	

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

At current levels, staff interact with 26 residents monthly, with a subset of residents receiving weekly counseling. With a full time staff member, we hope to roughly double our number of residents served and to increase the frequency of services provided

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

We are looking to hire a new staff member to work full time at the Evanston sites; without City funding, are only able to cover 30% of FTE costs.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

Currently we have one staff member working part time at the sites, engaging with 26 residents at varying levels of intensive services.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

Thresholds staff members are skilled in providing trauma informed care and working with clients with complex behavioral and mental health needs. Case managers use strengths based assessments and motivational interviewing when setting out service plans for participants.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

In addition to the ongoing quality instruction in mental health evidence-based practices and leadership available to all current staff, all new staff are required to attend four days of training as part of New Staff Orientation (NSO). During this orientation week, Workforce Development staff members teach sessions on ethics, cultural humility, clinical documentation, safety practices while working in the field and at Thresholds sites, and clinical interventions. Currently, all trainings sessions are conducted virtually.

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

Under current staffing levels, case managers hold open office hours for roughly 13 hours/month at each site. Meetings occur

regularly for some participants and as needed for others, dependent on the level of service needed. Case managers also meet with property managers to identify residents who may not be coming to office hours for case management but who have immediate needs, and as needed case managers will conduct outreach to residents onsite. While Thresholds staff and property managers work together to provide continued outreach to potential participants who may be hesitant to engage, participation is voluntary, and residents who change their minds about meeting with case managers are welcome at any time.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

The goal-identifying process is a collaborative one, and residents work with staff members to identify the resources they most need to continue living independently. Motivational interviewing and SOAR techniques are crucial elements of this process, and residents are encouraged to think broadly about their needs and goals. Rather than providing expected goals, case managers prioritize residents' self-identification of what successful independent living looks like. No documents are required for intake or for the service plan.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

As our residents are seniors and people with disabilities, most service plans are geared toward facilitating independent living and maintaining or improving health. The most common component is ensuring the coordination of residents' healthcare, which involves working with healthcare providers, insurers, and administrators. In addition to regular contact with primary care providers, residents often need specialized care. Another key concern for residents is food security and access to transportation, which require coordination with local food depositories and other agencies such as Meals on Wheels the Greater Chicago Food Depository. Isolation is another key issue for seniors in particular, and most service plans involve a socialization component to help residents stay active in their communities. Access to technology is an important issue for socialization purposes as well as connecting to DHS and Medicaid, and case managers help residents use phones and stay connected. For some participants jobs and budgeting are key concerns, and case managers can work to address these goals where they are relevant, but for most residents given their age and/or level of disability these areas are not primary issues.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

Service plans are reviewed twice a year in collaboration with the client. Thresholds has developed a template for service plans and progress notes which will be utilized for this project. Progress notes are entered within 7 days of service and reviewed monthly with the supervisor. If a resident is also a Thresholds member, progress notes in SmartCare, our Electronic Health Record. The target for notes entering is three business days after service provided.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

Engagement patterns for individual clients vary widely based on the level of client needs. Some clients drop in as needed with specific tasks with which they need assistance, or with updated information on their medical conditions. For some residents, weekly counseling and conversations are more appropriate, as the socialization opportunity is itself helpful for some residents with serious mental illness. This need became especially crucial during the pandemic, as medically vulnerable people have had to take significant steps to isolate themselves from in-person contact with others to stay safe from COVID-19. Property managers also help monitor residents' needs and alert case managers to emerging issues in instances where residents require more intensive outreach and intervention. However, at current levels of staffing funding, many residents are not able to meet with staff with a frequency level that would be optimal for their specific needs. The most important form of progression in the case management relationship is that over time residents become more familiar and comfortable with case managers and so will engage with them more readily with concerns or needs. Trust and communication are key in the staff/client relationships, and building that trust allows staff to better serve residents.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

Staff use project-specific service plans and progress notes which Thresholds has developed.

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

Supporting independent living is an ongoing process, and as residents age they will face new physical, mental, emotional, and social challenges. Rather than orienting our practice toward financial self-sufficiency goals, a process with a defined end-point that is common at our family sites, we seek to provide ongoing support to residents at our senior sites to make sure they can age in place with health, dignity, and community.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the barriers to receiving those services?**

Healthcare: Accessing referrals to specialists; Receiving dental care; Reminders for appointments; Transportation to appointments; Medicaid redeterminations.

Behavioral health: Socialization; Maintenance and cleanliness in apartment units (including necessary interventions in order to

keep residents compliant with leases).

Food: Accessing and renewing SNAP benefits; Connecting to Meals on Wheels and St. Vincent de Paul food program; Other local food pantries.

Transportation: Obtaining and renewing free ride cards.

Socialization: Participating in resident social life within the building and in the Evanston community; Operating smartphones and using email; Acquiring and renewing Safelink benefits.

Accessing benefits: SNAP, LIHEAP, Medicaid; Other SSA and DHS.

Barriers to these resources are primarily related to access to information. Many benefit renewals and other resources must be accessed online. While computers are provided in a communal computer lab, residents are not always familiar with how to operate them, or where to find resources on the Internet. Similarly, many residents have smartphones but do not know how to take advantage of the full range of connectivity benefits smartphones can offer. For some residents, behavioral or other health issues may prevent them from accessing the resources they need.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

Thresholds can evaluate for needs for clinical referrals for behavioral and mental health care and can facilitate internal referrals for clinical services when space is available. Residents will be entered into Thresholds' SmartCare system.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

Thresholds has MOUs for similar services with Mercy Housing, IFF, Center for Health and Housing (Flexible Housing Pool) and, in negotiation, TCB. The agreements cover the scope of services provided, frequency of visits, collaboration with property management, and reporting.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

Founded in 1959, Thresholds provides healthcare, housing, and hope for thousands of persons with mental illnesses and substance use disorders in Illinois each year. Through care, employment, advocacy, and housing, Thresholds assists and inspires people with mental illnesses to reclaim their lives. Last year, Thresholds served more than 12,500 adults and youth, with 75% of services delivered out in the community, representing more than 500,000 hours of care. Thresholds is one of the oldest and largest providers of recovery services for persons with mental illnesses and substance use disorders in Illinois. Thresholds offers 30 innovative programs at more than 75 locations throughout Chicago, the adjacent suburbs, including Evanston, and four surrounding counties. Services include assertive outreach, case management, housing, employment, education, psychiatry, primary care, substance use treatment, and research.

The Housing Authority of Cook County also known as the HACC, is the second largest public housing authority in Illinois. The HACC is a municipal corporation that was established in 1946 to serve 108 communities, as well as unincorporated areas in suburban Cook County. The Housing Authority of Cook County has operated the Jane Perlman Apartments in Evanston since 1978, and the Victor Walchirk Apartments since 1984, to provide decent and affordable housing to low-income seniors and persons with disabilities. The Housing Authority of Cook County administers several rent assistance programs to meet the housing needs of our rental participants. The HACC's conventional public housing program consists of over 2,100 owned units of low-income housing. The Rent Assistance Division services over 13,000 families, senior citizens, and persons with disabilities. Other programs such as our Mobility Assistance Program, Family Self-Sufficiency Program, and Home Ownership Program are designed to make a positive difference and help participants achieve independence. The HACC believes that, with the partnership of public and private resources, the goal of providing safe and desirable housing in viable communities, for all County residents can be successfully accomplished.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

Thresholds is an organization with an \$80 million budget and thousands of staff members. Thresholds has robust policy development and management staff. Thresholds is accredited by CARF.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

Thresholds conducts annual client surveys internally, and the internal quality team works to integrate the information yielded by these surveys into policy and practice changes that will improve client experience.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

HACC Executive Director: Rich Monocchio (white, male, 8 years in role)

Chief of Staff: Alesia Hushaw (Black/African American, female, 5 years in role)  
Chief Financial Officer: Karl Becker (white, male, 10+ years in role)

Thresholds staff demographics:

530 White  
486 Black  
1 American Indian  
34 Asian  
2 Native Hawaiian/Pacific Islander  
32 multiracial  
97 Hispanic

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

039642046000

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

- Yes  
 No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

IF "YES," ENTER "NA."

N/A

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

The Jane Perlman Apartments are located at 1900 Sherman Ave and the Victor Walchirk Apartments are located at 2300 Noyes Ave. Residents live at the facilities.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

Emily Orenstein

**Budget** [top](#)

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Funding Request		USD\$ 70,000.00	USD\$ 30,000.00
<b>Total</b>	<b>USD\$ 0.00</b>	<b>USD\$ 70,000.00</b>	<b>USD\$ 30,000.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
Coordinator salary/benefits	USD\$ 30,000.00	USD\$ 100,000.00	USD\$ 70,000.00
<b>Total</b>	<b>USD\$ 30,000.00</b>	<b>USD\$ 100,000.00</b>	<b>USD\$ 70,000.00</b>

**Budget Narrative**

Previously we spent \$30,000/year on part time services, financed by cash flow from tenant rents. Thresholds currently performs 300 hours/year of unbilled case management work, or 30% of an FTE. With this funding, we would be able to hire a full-time staff member to serve as a Case Manager to serve our Evanston properties. All funding will go toward staff salary and benefits. We anticipate a new hire.

**Program Outcomes** [top](#)

**Program Outcomes**

	Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
1	Increase resident awareness of benefits of case management	Number of residents who have regular contact with case workers			0			0
2	Increase proportion of residents who are successfully enrolled in assistance programs for which they are eligible (Safelink, SNAP, etc)	Number of residents enrolled in benefits programs			0			0
3	Decrease number of residents who are in violation of their leases due to maintenance or behavioral issues	Number of lease violation issues brought to property manager			0			0
4	Increase resident quality of life and satisfaction with their community	Conversations and interviews with residents			0			0
5					0			0
<b>Total</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

### Program Line Item Expenditures

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0

10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

**Documents** [top](#)

<b>Documents Requested *</b>	Required?	<b>Attached Documents *</b>
REQUIRED FOR ALL EXTERNAL APPLICANTS. Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.	✓	<a href="#">Financials</a>
REQUIRED FOR ALL EXTERNAL APPLICANTS. Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.		<a href="#">HACC Annual Report</a> <a href="#">Strategic Plan</a>
Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).	✓	<a href="#">501c3</a>
Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).		
Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).		
Brief biographies of key staff including demographic information.	✓	<a href="#">Bios</a> <a href="#">Thresholds senior staff</a>
Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).		
Supplemental information relating to your program or agency, as applicable.		
Form used to document income of participants to establish eligibility.		
HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants. <a href="#">download template</a>		<a href="#">AMI</a>
Policies/procedures for case management process and case file documentation/maintenance.		
REQUIRED FOR ALL EXTERNAL APPLICANTS. Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.	✓	<a href="#">Chart of Accounts</a>
Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.		
REQUIRED FOR ALL EXTERNAL APPLICANTS. Statement of operating revenues and expenditures for	✓	<a href="#">Budget</a>

most recently completed fiscal year (not required for City programs).

Organizational commitment to equity, diversity and inclusion.

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[Budget](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

[Board of Directors](#)

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form.



[Conflict of Interest](#)

[download template](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.



[Duplication of Benefits](#)

[download template](#)

\* ZoomGrants™ is not responsible for the content of uploaded documents.

Application ID: 351009

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## Infant Welfare Society of Evanston Teen Baby Nursery - IWSE

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 75,000.00** Requested

Submitted: 4/20/2021 8:58:57 PM (Pacific)

### Project Contact

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Tel: 847-491-9650

### Additional Contacts

*none entered*

### Infant Welfare Society of Evanston

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Evanston, IL 60202  
United States

### Executive Director

Stephen Vick  
[stephenvick@iwse.org](mailto:stephenvick@iwse.org)

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Web [www.iwse.org](http://www.iwse.org)

## Application Questions [top](#)

**1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?**

Families are recruited through our ERSEA coordinator that is funded by Early Head Start (EHS). The focus of this position is on Enrollment, Recruitment and Eligibility for the program. Early Head Start guidelines work with the lowest income families in economic challenge. EHS guidelines also highlight DCFS wards, homelessness and families with disability needs and services. There are specific guidelines and criteria for services and families are ranked based on highest needs. If there are no slots available once a family is deemed eligible and scored for highest need they will be placed on a waiting list. Other organizations often refer families to us. For example, we have a contract with ETHS and they refer teen parents for our services and early education programming at Teen Baby Nursery. Other partner organization and City programs such as the youth and young adult division in Parks and Recreation have often referred clients to us for wrap around and child care services. Most families come in to our program via word of mouth from other parents and families. However we may get 25% to 30% of our families from straight partner and community referrals.

**2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.**

The Infant Welfare Society of Evanston and specifically Teen Baby Nursery (TBN) serves parents ages 14-25 and their children ages 0-3. We also work with prenatal families in their planning and preparation for care. As an Early Head Start (EHS) provider we are mandated to serve the families that are at the Federal Poverty level as well as give priorities to families that are homeless, DCFS involved and have children with disabilities. Because TBN is the only program in Evanston that serves our youngest parents, ages 14 to 25 we have specialized programming that provides mentoring, support and wrap around case management services. We have special relationships with entities such as ETHS that ensure the youngest parents in Evanston are directed to receive our support. Because these services target the lowest income residents and predominantly Black and Brown residents in Evanston we are supporting the goals of providing equity in service provision to make the greatest impact to those that most need it. These requested dollars go directly to support the budget of Teen Baby Nursery which provides case management and family support through goal planning, mentoring, counseling groups, referrals and emergency assistance. WE not only work with the parents and families but provide the highest level of early childhood education as we are NAEYC accredited and have the Gold Circle rating from The State of Illinois which is the highest level of certification for early childhood providers. The work we do on social emotional, developmental and educational support lays the foundation in the first 1100 days of life for success in elementary, secondary and college. Studies show that brain development

grows most rapidly in the first 3 years, our work literally builds millions of synaptic connections that solidify successful outcomes in education, health and economic outcomes. Teen Baby Nursery directly impacts equity outcomes from direct intervention with children at the earliest ages and walking alongside and supporting families and care givers to be the best they can be.

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

At Baby Toddler Nursery we have a capacity to serve 16 children 0-3 at any one time and their families that can be up to 50 people including the immediate households, such as grandparent caregivers. Once we are at capacity we have a wait list that holds place for children as slots open. At age three children move to Pre-K programming such as Head Start or other 3-5 services. As slots open families are moved into the program as early as 6 weeks old. We currently are ramping up our capacity due to COVID-19. In the past year, all of our Early Childhood programs have been operating at reduced capacity, due to the Coronavirus and the mandates the state has imposed. As these mandates are lifted and people gain more confidence in Vaccine outcomes our recruitment specialists will bring our capacity back to full level. We anticipate to be back to 16 children in our program by July/August.

**4. Does demand fluctuate throughout the year? If so, please explain.**

Yes it can fluctuate. We tend to have more of a demand in Spring/Summer as people are looking for work and need child care. Many of our parents have seasonal/part-time jobs that are unstable. During the Pandemic we have obviously had reduced numbers.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

The entire family engages in the case management services. Service plans and goal setting are initiated at intake. Our clients are the infant/toddler, parent or caregiver, grandparents and anyone living within that household. Many times services and referrals are related to mental health, housing and homelessness, domestic violence, drug and alcohol use and support with job and career development. As we serve a very young population at TBN, support in staying in school as a young parent or getting a post secondary degree is a priority. All of our families are low income, Black and Brown residents of Evanston. Again these families must qualify for EHS services, are evaluated and prioritized for the highest need and are the most challenged economically in the City.

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

23	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
20	Unduplicated Evanston residents to be served in 2021	
23	Unduplicated low/moderate income people to be served in 2021	
18	Unduplicated people served in 2020	
15	Unduplicated Evanston residents served in 2020	
18	Unduplicated low/moderate income people served in 2020	
15	Unduplicated low/moderate income Evanston residents served in 2020	
132.00	<b>TOTAL</b>	

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

As of January 2021, 7 families were enrolled at TBN. Our goal by August 2021 is to be at full capacity which is 16 children. Enrollment has been down since the beginning of the COVID 19 pandemic.

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

Case management staff:

Female, Haitian American, 4 years in current role, Bachelors Degree in Child and Family Services. No new staff will be hired.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

Our Family Advocate has a maximum caseload of 16 families. 16 families is the maximum amount of children that we can serve. However the total amount of families served can vary due to transitions.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

The Family Advocate engages the families in a variety of ways after the initial intake is complete. A strength and needs assessment is completed to determine which areas of support needed are identified and the process of goal setting is implemented. Once goals are set the Family advocate makes a record of each family's goals and creates a timeline of when to follow-up with the families to see progress and what other supports are necessary for them to attain their goals.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

Professional development is provided for the Family Advocate (FA) both internally and externally. The FA has received monthly professional development training from Evanston/ Skokie District 65, H.G Jones & Associates for ERSEA, Early Head Start and PD's provided by IWSE Leadership.

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

Meetings can vary depending on the individual needs of each family. It can take up to 1 ½ hours to complete an intake and fully enroll a family. After the initial intake is complete then the FA goes into goal setting which can range anywhere from 30 minutes to an hour. Currently there is no specific measurement tool that is used to aggregate parent engagement. If participants decide not to show according to a scheduled meeting then the FA will reach out to reschedule the appointment emphasizing the importance of meeting regularly to discuss progress.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

During intake meetings the FA will ask families for a Specific Measurable Achievable Realistic Time-based (SMART) goal, what strategies they will take to complete the goal, who is responsible for assisting with the goal, when they expect to accomplish the goal and comments of the goals process. A very important step to this process is parent commitment. So after each goal is made the FA will have the parents sign the goals sheet signifying that they will commit to working at them. Currently there is not requirement of proof that parents have to bring in of achieving their goals. Effective communication is a strong component in building relationships with the participants. Through follow-up meetings we discuss progress, and parents reactions to their goals reveals if they have attained them or not.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

Individual goal plans can vary in variety and degree of goals to be achieved. An example of a goal can be employment. The FA will help and assist a family with their resume and cover letter. Next step would be to look at all applicable job openings in the community of the parents' choice. Then the FA and the parent will track goals by communicating and writing down the steps they're taking toward their goal and document this in our online database used by the Office of Head Start. A follow-up meeting is then held with the family to determine the outcome of the job search. All of these encounters are recorded and reviewed by the EHS Manager.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

The FA review goals once a week and via unscheduled visits when children are dropped off each day. Electronic communication such as text messaging and email has been a great help in staying connected with families. Once the parent has accomplished a step in their goal, it is then updated in the online database. Currently we have 10 families who have made goals during our enrollment intake. The FA completes at least one strength based assessment with parents three times a year. The strength based assessment is added to the online data base system under Family Outcomes.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

Every family is different with how they interact with the Family Advocate. Families engage with the Family Advocate during parent meetings and individual meetings to update their goals and child's binder. Parent meetings can last from 30 minutes to 1 hour. Parent education workshops and trainings are conducted monthly. A range of topics based on parent needs and interest will be held. The workshops or trainings topics may include financial planning, health and safety, housing, and trauma informed care with a mental health focus.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

The Family Advocate documents parent goals by inputting their information into the online database under the Family Services tab. The FA will add a communication log and fill in the needed information if applicable. The Family Advocate will then add documentation and add an action that the families have completed their goals. All goals are documented on the

parent goal sheet.

**18. When does a client graduate from or complete case management services? Include any “check-in” or follow up with those clients.**

When a family is exiting out of a program, the Family Advocate will have communication with the parent about the exit/transition process. The Family Advocate and the Teacher will communicate with the parent about finding a local program to continue services. Parents will fill out a transition and be referred to another program in the area that can meet their needs. Once a participant has aged out of our program and has concluded the exit process, all information is filed and stored for up to ten years.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the barriers to receiving those services?**

The services most families need are the following:

1. Counseling and mentoring
2. Support groups for depression, domestic violence and other mental health issues.
3. Housing insecurity and homelessness
4. Low wage, part-time job challenges as well as lack of job skills and training
5. Drug and alcohol abuse
6. Support in learning how to support, nurture and educate their children
7. General goal setting and planning to achieve self-sufficiency

The barriers to receive these service can be personal in nature and sometimes systemic. For example many people in the Black and Brown community do not lean towards therapeutic support and interventions such as counseling. It takes trusted and caring relationships to build confidence and willingness to receive help and support. This is the main role of our Family Advocate case managers. Once we have trust and strong interpersonal relationships our services can more easily be provided. This is especially true with our youngest parents as they are children themselves. Even our older parents are developmentally much younger in age. That is why we serve parents ages 14 through 25.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

As families enter the program and are assessed for eligibility they are also given a service plan and their goals, challenges and needs are assessed and discussed. The Family Advocate meets with families regularly to review and assess these goals. All of this work is documented in the case manager/Family Advocates file and service plan for the parent or care giver. Once there is a need for a referral the information is shared, sometimes connections are made and everything is documented and tracked per policy. Services are often the following:

1. Counseling and mentoring
2. Support groups for depression, domestic violence and other mental health issues.
3. Housing insecurity and homelessness
4. Low wage, part-time job challenges as well as lack of job skills and training
5. Drug and alcohol abuse
6. Support in learning how to support, nurture and educate their children
7. General goal setting and planning to achieve self-sufficiency

Connections are often made from case manager to case manager. As stated sometimes support is needed as well as guidance to help connect the services and solidify a new trusting relationship with that community partner.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

Yes. We have many service agreements with partner organizations and are continually striving to strengthen these relationships in the community as we are not experts in everything. Some of our partners include:

The Childcare Network of Evanston  
Reba Early Learning Center  
Learning Bridge  
District 65  
Youth Job Center  
Family Focus  
Cherry Preschool  
The City of Evanston-Youth and Young Adult Division  
YWCA Evanston/North Shore  
McGaw YMCA  
Evanston Township High School  
Evanston Public Library  
Refugee One

Metropolitan Family Services  
Evanston Cradle to Career  
Skokie Public Library  
Beyond the Baby Blues  
Connections for the Homeless  
Erie Family Health  
Swift Child Care  
The Moran Center  
Books and Breakfast  
Curt's Cafe  
Evanston Community Foundation  
Erikson Institute  
National Louis University  
Northwestern University

Many of these agreements and MOU's are focused on information sharing, program and service support such as direct referrals like the Moran Center or Youth Job Center, partnership agreements and long term collective impact efforts such as Evanston Cradle to Career.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

IWSE has been in Evanston since 1913, over 108 years. We have four facilities, two in Evanston and two in Skokie/Morton Grove. TBN was started in the fifth ward Family Focus building in the early 90's, over 25 years. We have partnerships through EHS as a delegate agency to District 65 and are the only representative in the 5th ward of the Evanston school system.

IWSE's mission is to deliver exceptional care and education for infants and young children and support families' efforts to be effective parents and advocates in their child's learning and development.

We have a Board of 15 community members, approximately 50 staff and a leadership team of 8 people, made up of two senior Site Directors and an Executive Director. We are currently looking for a new Development Director who was separated from IWSE in December of 2020

The board is comprised of three committees and multiple ad hoc committees over the course of the year. These include the Executive committee, Development committee and Finance committee.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

We use multiple methods for documentation of services as we have contracts with Early Head Start, ISBE and other State entities and programs. We have written policies for financial procedures and use QuickBooks, CRM databases and other accounting tools.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

As an EHS provider we are mandated to have a parent policy council that is involved in programmatic and financial decision making. They approve budgets, are involved in senior hiring and the day to day classroom interactions of teachers and families. This has been challenging to keep up with during Covid-19 and we have had to be creative with remote communication.

We also communicate regularly with parents both in person and via surveys to gauge needs and address challenges. Building a strong parent outreach and partnership is central to our services.

Service delivery is constantly being assessed and adapted to other needs and concerns of our parents, families and community. One of our strengths has been our ability to adapt, change and grow. This is why we have been around for 108 years.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

Stephen Vick- Executive Director: Male, White-Jewish, 5 years in role.

Tiffany Culpepper- Site Director: Female, African-American, 5 years in role.

Mary Grace Aceron- Lead Teacher: Female, Asian-American, 4 years in role  
 Ilesha Lane- Lead Teacher: Female, African-American- 4 years in role  
 Lorie Saint Cyr- Family Advocate: Female, Haitian-American- 3 years in role

In group listed above 80 % are POC.

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

079763504

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

- Yes
- No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

IF "YES," ENTER "NA."

NA

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

2010 Dewey Ave. in the 5th Ward of Evanston- Family Focus Building. Participants arrive on their own. If needed they can get a voucher for transportation if there is an emergency.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

Stephen Vick

**Budget [top](#)**

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Funding Request	USD\$ 57,915.00	USD\$ 75,000.00	
Site Administered Contract CCAP (IDHS/DCFS)	USD\$ 155,943.00	USD\$ 169,737.00	
ISBE Food Program/CACFP	USD\$ 11,896.00	USD\$ 16,346.00	
School District 202	USD\$ 41,000.00	USD\$ 41,000.00	USD\$ 41,000.00
Early Head Start/DHHS	USD\$ 166,973.00	USD\$ 209,250.00	USD\$ 209,250.00
Parent Fees	USD\$ 12,844.00	USD\$ 14,820.00	
Grants/Annual Giving/Other	USD\$ 12.00		
<b>Total</b>	<b>USD\$ 446,583.00</b>	<b>USD\$ 526,153.00</b>	<b>USD\$ 250,250.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
City of Evanston Funding Request			
Wages	USD\$ 279,386.00	USD\$ 291,938.00	USD\$ 46,087.00
Benefits	USD\$ 41,842.00	USD\$ 44,311.00	USD\$ 6,995.00
Family Participation Expenses (food, transport)	USD\$ 1,070.00	USD\$ 3,659.00	USD\$ 578.00
Mileage	USD\$ 380.00	USD\$ 683.00	USD\$ 108.00
Staff Professional Development	USD\$ 2,529.00	USD\$ 6,874.00	USD\$ 1,085.00
Contractual Services	USD\$ 19,230.00	USD\$ 23,878.00	USD\$ 3,769.00
Communications	USD\$ 3,281.00	USD\$ 4,784.00	USD\$ 755.00
Supplies	USD\$ 31,599.00	USD\$ 44,897.00	USD\$ 7,087.00
Occupancy	USD\$ 39,301.00	USD\$ 48,761.00	USD\$ 7,698.00
Equipment	USD\$ 1,023.00	USD\$ 2,606.00	USD\$ 411.00
Publications, Subscriptions & Other Expenses	USD\$ 3,058.00	USD\$ 2,706.00	USD\$ 427.00
<b>Total</b>	<b>USD\$ 422,699.00</b>	<b>USD\$ 475,097.00</b>	<b>USD\$ 75,000.00</b>

**Budget Narrative**

Infant Welfare Society of Evanston/Teen Baby Nursery operates on a July 1 - June 30 fiscal year. Due to the health crisis, recent revenue and expenses have been reduced; our 2021 application year looks toward the future with an optimistic eye, projecting fuller enrollment with increased revenue and expenses to support the children and families in Teen Baby Nursery programming. In addition, a contract negotiation has provided additional Early Head Start funding to support our most at-risk children.

Though our original budget is showing a surplus, due to COVID-19 reductions in enrollment our actual CCAP dollars will be reduced by approximately 100k. This would create a shortfall in revenue in our TBN budget and a deficit in the 2021 year by over 50k.

**Program Outcomes** [top](#)

**Program Outcomes**

Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
1	100% of enrolled children (16) will be screened for physical, developmental, language, and social emotional development/delays.	16	16	32			0
2	90% of children (14) will meet widely held expectations and progress across a developmental continuum as expected. When this does not occur, screenings and evaluations will determine the need for Early Intervention services.	14	14	28			0
3	80% of children (13) will progress at least one step on Teaching Strategies GOLD's age-appropriate continuum in both their social emotional and language development.	13	13	26			0
4	70% (11) of parents or other family members in the household will read to their children at least 4 times a week.	11	11	22			0
5	90% of teen/young adult parents will attend an educational, vocational or job training program and complete as scheduled, or will be employed.	14	14	28			0
<b>Total</b>		<b>68</b>	<b>68</b>	<b>136</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Program Line Item Expenditures**

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0

7						\$ 0
8						\$ 0
9						\$ 0
10						\$ 0
11						\$ 0
12						\$ 0
13						\$ 0
14						\$ 0
15						\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Documents [top](#)

#### Documents Requested \*

REQUIRED FOR ALL EXTERNAL APPLICANTS. Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.

#### Required? Attached Documents \*



[Audit 2019 - 2020](#)

[990](#)

[Annual Report 2019 - 2020](#)



[501\(c\)\(3\) letter](#)



[Bios from TBN](#)

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

Supplemental information relating to your program or agency, as applicable.

[Sample Case Notes](#)

Form used to document income of participants to establish eligibility.

[EHS Enrollment Criteria](#)

HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Policies/procedures for case management process and case file documentation/maintenance.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.



[Account List](#)

[Class List](#)

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).



[Audit 2019 - 2020](#)

Organizational commitment to equity, diversity and inclusion.

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[Budget 2020 - 2021](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

[Board List](#)

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form.



[Conflict of Interest](#)

[download template](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.



[Duplication form](#)

[addendum](#)

[download template](#)

\* ZoomGrants™ is not responsible for the content of uploaded documents.

Application ID: 348307

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## James B. Moran Center for Youth Advocacy Moran Center Case Management Services Program

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 75,000.00** Requested

Submitted: 4/21/2021 1:21:13 PM (Pacific)

### Project Contact

Linda Tucker  
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Tel: 847-492-1410

### Additional Contacts

*none entered*

### James B. Moran Center for Youth Advocacy

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### Executive Director/Staff Attorney

Patrick Keenan-Devlin  
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## Application Questions [top](#)

### 1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?

The Moran Center for Youth Advocacy's Social Work Program clients are exclusively referred internally through the agency's legal programs – Emerging Adult/Juvenile Delinquency Practice, Education Advocacy Program, and the School-Based Civil Legal Clinic.

Referrals to the Moran Center's legal services are then made by partnering social service agencies, school social workers, educational administrators, and the courts. Consents for release of information are obtained so that pertinent information may be shared with referring agencies, and continuity of care provided. Referrals are documented in our client management database, LegalServer, which tracks referrals for reporting purposes.

### 2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.

Putting justice into action, the Moran Center works to promote the social, emotional, and developmental needs of the most marginalized children, youth, and families in Evanston. Primarily focusing on low-income Evanston youth and young adults of color up to age 26 and their families, we seek to remedy the injustices they experience while struggling to make ends meet, coping with mental health issues, contending with difficult legal challenges, and hoping to be granted a second chance to stay out of destructive institutions. Our trauma-informed Social Workers/Case Managers provide counseling and case management to promote the mental and behavioral health of the youth we serve, reducing social isolation and supporting community inclusion.

All the youth and families we serve come from families stressed by poverty, housing insecurity, unemployment, substance abuse, violence, and mental health challenges, legacies of racial and ethnic oppression. Almost all of our clients have experienced Adverse Childhood Experiences, or ACES, such as child abuse or neglect, exposure to violence, and/or parental loss. The Moran Center's Social Work Program works to put protective factors in place, supporting them emotionally as they grapple with past traumas, begin to heal, and develop tools to redirect their lives toward a more hopeful and productive future.

The Social Work Program embodies the Moran Center's deep commitment to racial and socioeconomic equity and is designed to remove barriers and expand opportunities to families who may not otherwise have the social capital or resources

to access critical supports. With additional and sufficient funds from the City of Evanston, the Moran Center could both maintain and expand services by potentially setting up the agency to hire a part-time Social Worker/Case Manager. Hiring an additional Social Worker/Case Manager would allow the Moran Center to accomplish a critical draft goal set out in the 2021-2024 Strategic Plan. With the present high case volumes, an additional part-time Social Worker/Case Manager would allow the Moran Center to provide case management and therapeutic services more consistently to all internal referrals made by the legal programs. We presently have a 2:1 ratio of attorneys to Social Workers/Case Managers that make caseloads often unduly burdensome for the Moran Center's Social Workers.

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

The Moran Center is committed to serving all disinvested youth and families who qualify for our services. We do not have a formal waiting list. We receive many calls from individuals who for one reason or another are not eligible for our services and those individuals are referred to organizations such as Legal Aid Chicago ("LAC") or Coordinated Advice & Referral Program for Legal Services ("CARPLS"), among others. Occasionally a client is "conflicted out" of our services. For example, if we are representing one person involved in an incident, we cannot represent another involved in the same affair.

**4. Does demand fluctuate throughout the year? If so, please explain.**

The Social Work Program mirrors legal services with more criminal matters being referred in the summer, more education-related cases being assigned towards the end and the start of the academic year, and civil matters referred throughout the year.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

To qualify for the Moran Center's core legal services, and thereby our Social Work services, users must earn less than 80% of the median income level, though 99% of Moran Center clients have incomes below the poverty level, and reside in Evanston Township.

66% of the Moran Center's Social Work clients (i.e., Case Management clients) identified as "very low income" (< 30% of the median income); 22% low income (<50% of the median income); 11% had "moderate incomes" (<80% of median income); and 1% had incomes > 80% of median income. Notably, 40% of our new Evanston clients had a special need. Among these clients, 17% were homeless; 37% resided in female-headed households, often with a grandparent. Regarding age, 13% of our Social Work clients are children under the age of 17 and 82% are adults. Our client population is racially and ethnically diverse and identifies as 6% White/Non-Hispanic, 0% as White/Hispanic, 76% as Black-African American/Non-Hispanic, 0% as Black-African American/Hispanic, 8% as Other Multi-Racial/Non-Hispanic, 4% as Other Multi-Racial/Hispanic, and 6% as other.

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

111	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
93	Unduplicated Evanston residents to be served in 2021	
110	Unduplicated low/moderate income people to be served in 2021	
97	Unduplicated people served in 2020	
78	Unduplicated Evanston residents served in 2020	
96	Unduplicated low/moderate income people served in 2020	
77	Unduplicated low/moderate income Evanston residents served in 2020	
662.00	<b>TOTAL</b>	

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

78 Evanston Case Management Participants Enrolled 1/1/21, 20 New Evanston Participants Expected to Enroll by 12/31/21

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

Director of Social Work Services: Female; White/Non-Hispanic; 11 years in her current role; LCSW with prior experience working in a juvenile detention center and providing crisis counseling to runaway youth; M.S.W. from Loyola University Chicago and B.S. from Eastern Illinois.

Social Worker 1: Female; White/Non-Hispanic; 6 years in her current role; LCSW with experience working with children, adolescents, and adults in a variety of clinical settings, including therapeutic day schools; M.S.W. from Loyola University Chicago and B.A. from the University of Uppsala and Örebro University.

Social Worker 2: Female; Multi-Racial/Non-Hispanic; less than 2 years in her current role; MSW with experience in individual and group therapy within the field of addictions; presently pursuing licensure for LCSW; M.A. from The University of Chicago; B.A. from The University of Michigan.

As previously stated, we hope to hire a part-time Social Worker/Case Manager to meet the current capacity; however, the hire is contingent upon receiving adequate funding from the City of Evanston.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

There are currently three Social Workers/Case Managers on staff: Director of Social Work Services/Case Manager: 58 Clients, Social Worker/Case Manager 1: 24 Clients, Social Worker/Case Manager 2: 15 Clients

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

The Social Work Program employs multiple therapeutic approaches to address the wide range of clients served by the Moran Center's legal programs, including interpersonal skills training, Cognitive Behavioral Therapy, strengths-based assessment and intervention, aggression replacement treatment, family-integrated transition planning, and Multisystemic therapy. All modalities are practiced through a trauma-informed, healing-centered lens that is driven by the client.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

The Moran Center supports the Social Work Staff in accessing and attending external professional development workshops and conferences. Social Workers typically attend two to three conferences per year (i.e., National Association of Social Workers "NASW" Illinois Conference, National Association of Public Defense "NAPD" National Conference, National Organization of Forensic Social Workers "NOFSW" National Conference, etc.) focusing on the newest evidence-based practices pertaining to a multitude of issues faced by the Moran Center's clients including but not limited to trauma, substance abuse, childhood abuse/neglect, etc. In addition to large conferences, the Moran Center supports social work staff in attending relevant workshops regularly throughout the year. The Moran Center also provides development opportunities internally for all staff at least once per year on topics including healing-centered care, trauma-informed care, restorative justice, etc. The Moran Center does not formally have a minimum level of training required but does require a master's level degree with experience in the field to obtain employment.

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

Social Work/Case Management services are developed based on each client's individual needs. Social Workers/Case Managers schedule an initial intake followed by at least one additional meeting with clients solely to build rapport, to learn what the client wants, and to assess each client's needs. Based on the initial assessment, the Social Worker/Case Manager and client develop an appropriate Service Plan together. The frequency and duration of client contact then vary depending on the complexity of the client's needs. On average, Social Workers/Case Managers meet with clients once per week, but the frequency can be adjusted based on the client's level of need at any particular time. Social Workers/Case Managers utilize the Moran Center's data management system, LegalServer, to complete case notes to track and measure each client's level of engagement and progress. Client engagement is typically measured by how often the client attends clinical sessions, their level of participation during scheduled sessions, their responsiveness, and their follow-through on action steps built into their Service Plan. If a client is struggling to engage, Social Workers/Case Managers will first attempt to identify barriers/struggles leading to the lack of engagement and work with the client to address those barriers. A client always has a right to self-determination. Social Workers/Case Managers will continue to engage clients to a degree but will not force them to comply with services. Social Workers/Case Managers will inform a client who is not engaging that they are always welcome to re-engage if/when they are ready.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

When initiating services with a new client, Social Workers/Case Managers will spend at least three to four meetings building rapport and learning from their clients about their successes, challenges, and barriers prior to creating a Service Plan. The Moran Center's Social Workers/Case Managers find that by refraining from creating a Service Plan during the initial meeting (s), clients are more apt to engage in services, generally, and in ultimately developing a more meaningful Service Plan. Within the first month of commencing services, Social Workers/Case Managers invite clients to begin drafting their Service Plans - a client-driven process. Social Workers/Case Managers will then pull from what they have learned during the first month to help guide clients to create case management and therapeutic goals, action steps, timelines, and what success looks like to them as it relates to their plan. Clients are not asked to provide documents at intake unless they report they have received case

management services from other providers. If appropriate, the Social Workers/Case Managers will request those documents be provided to allow for the Moran Center to collaborate with other service providers. If necessary, safety plans are also created at that time.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

Client's Service Plans are individualized based on the complexity of their situation and their personally identified needs. Some of the common components that clients often include in their Service Plan are creating a resume, finding/maintaining a job, learning how to budget their money, obtaining their identification documents (State I.D., Social Security Card, etc.), accessing health insurance, and/or public benefits, accessing medical care (e.g., primary care, psychiatric services, dental services, etc.), seeking further education, securing stable housing, learning coping skills, and managing their emotions. Typical outcomes of Service Plans include clients taking necessary action steps, with the guidance and support of their Social Worker/Case Manager to complete their stated goals. Another common outcome is connecting clients with social service agencies that specialize in areas related to clients' individualized goals (i.e., housing, employment, health care, etc.). To track progress, Social Workers/Case Managers and clients refer to the client's Service Plan on a regular basis to check off/edit/update, as necessary. The Service Plan is reviewed at least once a month, but often more than that. Progress is tracked in LegalServer. The client's idea of success is noted for each goal within the Service Plan. Success may be completing a specific goal and/or may mean a client taking a few steps toward a goal. Success is also measured by the client's identification of what success looks like.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

Social Workers/Case Managers and clients refer to the client's Service Plan on a regular basis to check off/edit/update, as necessary. Service Plans are often reviewed multiple times per month, but at least once per month. Progress notes are documented in LegalServer following each interaction that a Social Worker/Case Manager has with their client. Progress notes contain basic content for that specific meeting including how the client presents (affect and mood), client's engagement level, basic concepts covered during that meeting, and any immediate or long-term action steps for the client and/or Social Worker/Case Manager to work on or complete in between meetings.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

The frequency and duration of meetings are determined by each individual client's needs, as well as the client's input of how often they would like to meet. Typically, Social Workers/Case Managers see clients once per week for approximately one hour. If it is determined by the Social Worker/Case Manager and the client that meetings are not necessary on a weekly basis, the Social Worker/Case Manager will reach out to the client with a phone call or an email during a non-scheduled week to check-in. Case management services typically progress into therapeutic services, which are also provided by the same Social Worker/Case Manager, as rapport is built.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

Social Workers/Case Managers use the Moran Center's client database system, LegalServer, to maintain client records. A case note is completed following each session. (See sample case management in the "documents" tab).

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

Clients complete case management services once they, with the input from their Social Worker/Case Manager, jointly decide that they have reached all their goals and no longer require assistance from their Social Worker/Case Manager. Moran Center Social Workers/Case Managers then check-in approximately once a month for three months following the case being closed out, via phone or email, to ensure that clients do not require any follow-up services. If they do, Moran Center Social Workers/Case Managers will assess the level of need at the time and the Moran Center's capacity to re-open a client's case or potentially refer to another social service provider/partner agency.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the barriers to receiving those services?**

To be effective in closing the opportunity gap for disinvested youth and families of color in Evanston, the Moran Center relies on strong connections with Evanston partners to foster family stability, support the social-emotional and developmental needs of marginalized youth and their families, and promote academic and job success. We work in partnership with Y.O.U. for youth development; Connections for the Homeless for housing homeless youth and families; Youth Job Center, Curt's Café, and Evanston Rebuilding Warehouse for essential employment and job training skills; and PEER Services, Metropolitan Family Services, Turning Point, the Family Institute at Northwestern University, Trilogy, Thresholds, and Erie Family Health Center for primary care, psychiatric, and substance abuse services. The Moran Center also works closely with the City of Evanston's Youth & Young Adult Division to provide mentorship, employment opportunities, and outreach to youth regarding their legal rights and responsibilities.

The barriers that our clients often face in reaching their stated goals vary. The Moran Center's clients sometimes have criminal

backgrounds which interfere with their ability to earn and maintain a job or secure housing. The lack of affordable housing in the Evanston area often forces Moran Center clients and their families out of Evanston to other suburbs of Chicago, the south or west sides of Chicago, or to the streets, therefore making it even more difficult to access service providers who they may feel connected to in our community. The limited access to psychiatric services, including waitlists and insurance limitations, cause clients to give up on receiving treatment that they may desperately need. Ongoing systemic racism and the unaddressed generational trauma that exists because of racism is a constant barrier to our clients receiving respect, humanity, and fair treatment from larger institutions including the criminal justice system, education system, healthcare system, etc.

Recognizing that Evanston has fallen short in removing barriers and tailoring services to the needs of all members of our diverse community, the Moran Center and eight other health, social service, early childhood, and youth outreach organizations created the "Evanston Collective" with a grant from Evanston Cradle to Career. The goal of this initiative is to create a seamless web of family support services that are culturally and linguistically attuned and responsive to the lived experiences of Evanston's most disenfranchised families.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

Referrals to the agencies identified above are made and followed up by the Moran Center's Social Workers/Case Managers. Consents for Release of Information are obtained so that pertinent information may be shared, and continuity of care provided. The Moran Center's Social Workers/Case Managers provide "warm handoffs" to refer clients to our partner agencies rather than simply giving clients contact information and expecting them to feel comfortable reaching out on their own. Social Workers/Case Managers use the Moran Center's deep relationships with partner agencies to personally bring clients to other service providers for their initial contact or at the very least make the phone call with clients to representatives that the Social Worker/Case Manager already knows and trusts. Referrals are documented in our case management database, LegalServer, which can track referrals for reporting purposes. One of the indicators we track is the percentage of clients who seek additional services and are then able to secure those services.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

The Moran Center has a signed Memorandum of Understanding ("MOU") with the Evanston Collective organizations - City of Evanston's Youth & Young Adult Division, Connections for the Homeless ("Connections"), Curt's Café, Erie Family Health Centers ("Erie"), Infant Welfare Society of Evanston ("IWSE"), PEER Services, Youth Job Center ("YJC"), and Youth & Opportunity United ("Y.O.U."). The purpose of the MOU is to create a seamless web of family support services that are culturally and linguistically attuned and responsive to the lived experiences of Evanston's most disenfranchised families. See the MOU attached.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

A 19-year-old African American father was charged with the death of his two-year-old son while attempting to revive him after his son stopped breathing. Two days later, the young father was found hanging in his jail cell and subsequently died after being transferred to three different medical facilities. This young man had no advocate, no access to family; he was dehumanized. This tragedy propelled then Alderman James B. Moran among others to create the Evanston Defender Project in 1976. Five years later, the organization was incorporated as the Evanston Community Defender Office, Inc. Renamed the James B. Moran Center for Youth Advocacy in 2010 in honor of Judge Moran, the agency serves as a zealous advocate for thousands of marginalized youth and their families in need of legal and social work services in Evanston.

Championing justice and restoring hope, the Moran Center's mission is to provide free, integrated legal and social work services to disinvested youth and their families in Evanston to improve their quality of life at home, at school, and within the community. Central to our mission is the belief that all children and their families deserve justice in the courtroom, access to the classroom, and restoration in the community to thrive. The Moran Center innovatively works to dismantle the local poverty-to-institutionalization pipelines.

The Moran Center's six staff attorneys, advocate for and represent youth in the courts and schools. Our three master's level Social Workers/Case Managers support the emotional needs of the youth and families we serve by providing trauma-informed therapy, crisis intervention, and case management. Our Development Team, led by the Director of Development & Communications raises funds to support our work and communicates our impact to the community at large. Promoting restorative practices, our Restorative Justice Coordinator advocates for and offers training to entities in employing restorative practices. Our Director of Operations and Administrative Manager oversee the internal workings of the agency, including human resources, technology, and finances. The Executive Director provides vision and leadership both within and outside of the organization.

This year, we hired an AmeriCorps VISTA who serves as the agency's Data Manager, helping streamline the Moran Center's data collection process and expand the utility of our client data management system.

The Moran Center has an active, 20-member Board of Directors with four working committees: Advocacy, Board Advancement, Fundraising, and Evaluation & Strategic Planning Committees. The Board works diligently to promote the Moran Center's mission and impact, increase and diversify our funding streams, and provide general oversight. To deepen community involvement, the Moran Center also has a diverse and engaged 22-member Advisory Council which provides guidance on our programming and activities.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

We have conscientiously fulfilled procurement and reporting requirements not only for CDBG-MHB, but also for the Access to Justice Initiative, Cook County Justice Advisory Council, and the Illinois Equal Justice Foundation along with other funders.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

The Moran Center has surveyed clients to receive their feedback on service delivery, satisfaction with services, unmet needs, and what the Moran Center could be doing better to help inform our current Strategic Planning process. The feedback will be incorporated into our new three-year strategic plan set to begin July 2021.

The Moran Center is currently working with data experts and educators from Northwestern University to create a text survey that will be sent directly to clients every three months to gather data pertaining to clients' experience, the progress they have made, and the impact that the Moran Center services have had on their day-to-day life. The text survey will be launched within the next two months.

The information gathered from the surveys will inform the Moran Center's ongoing effort to fill any relevant service gap that our clients are experiencing, as the Moran Center has historically done.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

Patrick Keenan-Devlin, Cis Man/White/Non-Hispanic, Executive Director (2016)/Juvenile Justice Attorney (2013).

Kristen Kennard, Cis Woman/White/Non-Hispanic, Deputy Director (2016)/Director of Social Work Services (2010).

Donna Masini, Cis Woman/White/Non-Hispanic, Director of Operations (2014).

Linda Tucker, Cis Woman/Black/Non-Hispanic, Director of Development & Communications (2020).

Thomas Verdun, Cis Man/White/Non-Hispanic, Director of Legal Services (2016)/Attorney (2003).

Lin-Wei Bonney, Cis Woman/Asian/Non-Hispanic, Administrative Manager (2021).

Pam Cytrynbaum, Cis Woman/White/Non-Hispanic, Restorative Justice Coordinator (2018).

Sarah Frudden, Cis Woman/White/Non-Hispanic, Assistant Education Attorney (2017).

Åsa Gezelius, Cis Woman/White/Non-Hispanic, Social Worker (2014).

Luca Guacci, Trans Man/Hispanic/Latinx/Middle Eastern/North African/Multi-Racial/Multi-Ethnic, Managing Attorney, Education Advocacy Program (2018).

Anya Joseph, Cis Woman/Asian/Asian American, Data VISTA (2020).

Megan McClung, Cis Woman/White/Non-Hispanic, Managing Attorney, School-Based Civil Legal Clinic (2018).

Chloe Reyes, Cis Woman/Asian/Asian American Caucasian/White Multi-Racial/Multi-Ethnic, Social Worker (2019).

Ina Silvergleid, Cis Woman/White/Non-Hispanic, Criminal Record Remediation Attorney (2020).

Recognizing that this continues to be an area of growth for the Moran Center, through Board and Staff recruitment, we have been intentional in cultivating leadership among people of color. We strongly believe that to move the needle toward greater racial equity, leadership needs to be more reflective of the people we serve. Currently, 25% of our Board members including the Vice-Chair, 28% of staff leadership/decision-making positions, and 37.5% of our program staff are persons of color. When positions on our staff or Board are open, we have made it a priority to recruit persons of color.

As part of the Moran Center's DRAFT 2021-2024 Strategic Plan, the Moran Center has prioritized including former clients and family members of clients/former clients in the organizational decision making of the Moran Center, building on our recent experience in hiring former clients to participate in the process of improving the responsiveness of Evanston's youth services.

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

085865483

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

Yes

No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

IF "YES," ENTER "NA."

NA

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

The Moran Center is in the Evanston Plaza, which is accessible, easily reached by public transportation, and convenient to Evanston Township High School. Our current address is 1900A Dempster Street, Evanston, IL. 60202.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

Patrick Keenan-Devlin, Executive Director

## Budget [top](#)

Funding Sources/Revenues	2020	2021	2021 Committed
City of Evanston Funding Request	USD\$ 75,500.00	USD\$ 75,000.00	
Program Fees	USD\$ 2,500.00	USD\$ 0.00	
Other Government Funds (Cook Cnty)	USD\$ 0.00	USD\$ 83,333.00	USD\$ 83,333.00
Foundation Grants	USD\$ 169,650.00	USD\$ 70,000.00	USD\$ 23,460.00
Corporate Sponsorships	USD\$ 0.00	USD\$ 0.00	
Individual Contributions	USD\$ 638,486.00	USD\$ 70,578.00	
Special Events	USD\$ 45,000.00	USD\$ 11,340.00	
Misc Income-PPP		USD\$ 37,724.00	
<b>Total</b>	<b>USD\$ 931,136.00</b>	<b>USD\$ 347,975.00</b>	<b>USD\$ 106,793.00</b>

Funding Uses/Expenses	2020	2021 Total	City Funds
City of Evanston Funding Request		USD\$ 0.00	
Salaries, Payroll Taxes, Benefits	USD\$ 718,161.00	USD\$ 261,300.00	USD\$ 75,000.00
Professional Fees/Contractual Services	USD\$ 26,750.00	USD\$ 13,833.00	
Program Supplies/Materials	USD\$ 13,200.00	USD\$ 10,840.00	
Office/Program Space	USD\$ 91,090.00	USD\$ 33,043.00	
General Operating	USD\$ 75,085.00	USD\$ 28,301.00	
Equipment & Other Fixed Assets	USD\$ 6,850.00	USD\$ 658.00	
<b>Total</b>	<b>USD\$ 931,136.00</b>	<b>USD\$ 347,975.00</b>	<b>USD\$ 75,000.00</b>

## Budget Narrative

The 2020 City of Evanston CDBG/MHB grant budget included all programs within The Moran Center. The significant drop in the 2021 budget is a result of splitting the organization into two buckets for the 2 CDBG grants this year. The Case Management budget reflects the case management/social work services only provided by The Moran Center and detailed in the grant application. The total of the Case Management budget and Safety Net budget reflects the total increase projected for the organization's wrap-around programs.

The \$75,000 would fund 28% of salary and benefits (\$24,000) of the current 1.0 FTE Director of Social Work/Case/Management Services, and fund 52% of salary and benefits (\$30,000) for one current 1.0 FTE Social Worker/Case Manager and fund 44% (\$21,000) of a second current 1.0 FTE Social Worker/Case Manager.

**Program Outcomes** [top](#)

**Program Outcomes**

	<b>Outcome</b>	<b>Indicator (How was success measured?)</b>	<b>Goal # (G): Jan-June</b>	<b>G: July-Dec</b>	<b>Goal Total</b>	<b>Actual # (A): Jan-June</b>	<b>A: Jul-Dec</b>	<b>Actual Total</b>
1	Social Work/Case Management clients will successfully grow self-efficacy (i.e. self-awareness, confidence, advocacy, and conflict resolution skills).	70% of youth will report and/or demonstrate increased levels of self-efficacy. Data source: Pre- and post-intervention surveys. LY end-of-year actuals 80/95 clients were successful.	33	33	66			0
2	Legal/Social Work clients will access necessary community services to strengthen their network of support.	90% of clients who desire access to additional resources will be assisted in obtaining services. Data source: Clinician surveys. LY end-of-year actuals were 91/95 clients were successful.	42	42	84			0
3	Social Work/Case Management clients will be able to identify at least one trusting adult, leading to more positive social-emotional outcomes.	80% of clients will report that they have successfully established a trusting relationship with at least one adult in the community who they can rely on. Data Source: Client survey.	64	64	128			0
4					0			0
5					0			0
<b>Total</b>			<b>139</b>	<b>139</b>	<b>278</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Program Line Item Expenditures**

<b>Item Description</b>	<b>Total Budget</b>	<b>City of Evanston Funds</b>	<b>Jan-June</b>	<b>July-Dec</b>	<b>Spent to Date</b>
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0

15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

## Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Documents [top](#)

#### Documents Requested \*

REQUIRED FOR ALL EXTERNAL APPLICANTS. Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

Supplemental information relating to your program or agency, as applicable.

Form used to document income of participants to establish eligibility.

#### Required? Attached Documents \*



[FY End 6.20-990](#)

[FY End 6.30.21-Audit](#)

[Annual Report](#)

[Strategic Plan](#)



[501 c3](#)

[Non-discrimination Policy](#)



[Brief Biographies](#)

[Client Complaint Procedure](#)

[Case Notes Form](#)

[Evanston Collective](#)

[Intake Form](#)

HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Policies/procedures for case management process and case file documentation/maintenance.

REQUIRED FOR ALL EXTERNAL APPLICANTS. ✓  
Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.

[Chart of Accounts](#)

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

[Foundations over \\$20,000](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS. ✓  
Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).

[Statement of EXP/REV FY End 6.20](#)

Organizational commitment to equity, diversity and inclusion.

[Diversity Statement](#)

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.

✓

[Operating Budget 20-21](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

[Board of Directors](#)

[Board Demographic information](#)

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form.

✓

[Conflict of Interest Form](#)

[download template](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.

✓

[Duplication of Benefits](#)

[download template](#)

\* ZoomGrants™ is not responsible for the content of uploaded documents.

Application ID: 349527

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## Metropolitan Family Services Family Coach Case Management

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 45,000.00** Requested

Submitted: 4/21/2021 8:54:41 AM (Pacific)

### Project Contact

Jennifer Michel  
[michelj@metrofamily.org](mailto:michelj@metrofamily.org)  
Tel: 312-986-4145

### Additional Contacts

*none entered*

### Metropolitan Family Services

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United States

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Web [www.metrofamily.org](http://www.metrofamily.org)

### President and CEO

Ricardo Estrada  
[estradar@metrofamily.org](mailto:estradar@metrofamily.org)

## Application Questions [top](#)

**1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?**

Metropolitan Family Services of Evanston (MFS-Evanston) will provide case management services using the Family-Centered Coaching model and the services will be provided by one full-time Bilingual (English-Spanish) Family Coach. Families with complex needs are often likely to access services through a community partner of MFS. Through their strong Evanston relationships, MFS plans to grow this service by working with other entities such as schools, other non-profits or governmental organizations, to link families and enroll them in services. Additionally, MFS will work with their full-time Communications Department to alert clients and the public of the available case management services. This information will provide the contact information of the Family Coach staff member with a brief description of the service.

**2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.**

For over 160 years, MFS has been serving vulnerable populations by providing services to communities in high need. In 2020, MFS adopted a Racial Equity, Inclusion and Justice (REIJ) Action Plan to ensure that MFS was promoting diversity, inclusion and justice at all levels, including in the populations served. MFS and its values have created a culture of diversity throughout every staff level and leadership. For the REIJ plan, the supervisor of this Family Coach position is on the agency-wide REIJ committee and leads activities at the Centers, which includes Evanston staff.

MFS is an organization that seeks to redefine its workplace culture, foster learning, and have open and sometimes challenging conversations across the entire organization. The REIJ work at MFS acknowledges the disproportionate effects of societal systemic oppression to Black staff members as well as other communities of color and recognize MFS's role must be more to create and build equitable and just systems for all. The purpose of the action plan is to create a more equitable environment and promote inclusiveness on every level. With this focus, MFS will better serve its clients through its empowered staff.

As it relates to this proposal, MFS is prepared to implement a Family-Centered Coaching Model; one that removes the burden of coordination of services from the client family and instead focuses on needs and goal setting. Because this funding focuses on the clients and their families instead of a type of services, MFS can improve outcomes for families. Importantly, this coaching model is rooted in the knowledge of the effects of trauma and systematic racism and works with families to achieve

outcomes and goals.

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

MFS-Evanston does not have a waitlist and this program will serve all Evanston residents.

**4. Does demand fluctuate throughout the year? If so, please explain.**

Yes, demand for services fluctuates throughout the year. The seasonal trends include an increase around the fall once children are back in school due to referrals from school partners. Services reduce around the holidays (November to January).

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

The families served by the Family Coach position will be:

- Very low income to low income (including individuals and families who do not have any income or who are homeless or struggling with housing and employment. Clients provide financial documents at the time of enrollment to show proof of income or lack of income. Examples of documents include: a paycheck, a tax form or a letter attesting that the client family does not receive any income.)
- Evanston residents of all ages. The case management will be done with adults (18+). This will include individuals and families. The services will be with the adult enrolled in the program, but the services will benefit children in the families as well as the adults.
- Evanston residents of all genders.
- Able to access services in English and Spanish. MFS will use a language line to assist when other languages are needed. MFS will serve all Evanston residents who require case management services with a focus on assistance for African-American and Hispanic families who face additional challenges and barriers.
- The full range of types of families. MFS serves all family units, including many female-headed households and single-parent households.
- Evanston residents who have disabilities and need case management services.

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

<input type="text" value="30"/>	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
<input type="text" value="30"/>	Unduplicated Evanston residents to be served in 2021	
<input type="text" value="30"/>	Unduplicated low/moderate income people to be served in 2021	
<input type="text" value="22"/>	Unduplicated people served in 2020	
<input type="text" value="22"/>	Unduplicated Evanston residents served in 2020	
<input type="text" value="22"/>	Unduplicated low/moderate income people served in 2020	
<input type="text" value="22"/>	Unduplicated low/moderate income Evanston residents served in 2020	
<input type="text" value="178.00"/>	<b>TOTAL</b>	

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

As of January 1, 2021, no participants were enrolled. The new Family Coach position will focus only on case management for Evanston families, and the number of people to be served is an estimate for the second half of 2021.

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

The following demographics are for MFS staff and supervisors. MFS is in the process of hiring the Bilingual (English-Spanish) Family Coach position and advertised the position after securing private dollars that will supplement the Evanston award. Jennifer Jenks is a 55-year-old Asian female and is the current Clinical Manager over a variety of programs at Metropolitan Family Services, including programs that are based out of the Evanston Center. She is Licensed Clinical Social Worker and an Illinois Certified Domestic Violence Professional. She graduated with a master's degree in social work from the University of Illinois at Chicago in 2004. Jennifer became an ICDVP in 2005 and an LCSW in 2006. Jennifer joined Metropolitan Family Services in 2013 and has been with the agency for more than eight years. Jennifer's specialty areas include domestic violence and behavioral health, including interventions for adoptive children and families. In 2020, Jennifer completed an intensive training program and became a Trust Based Relational Practitioner (TBRI), showing her commitment to continued growth and learning in the profession.

Haley Hansen is a 36-year-old white female. She is a Licensed Clinical Social Worker and a 2009 graduate of Loyola

University Chicago. Haley has worked with Metropolitan Family Services since 2012, beginning her career in behavioral health as a therapist in the Adult Mental Health program at Metropolitan's Southeast Chicago location. Haley was promoted to a supervisor position in 2015 and transferred to the North-Evanston-Skokie team in 2017 to help facilitate the expansion of the behavioral health program across the agency. Haley is the current clinical supervisor over the behavioral health programs, including those based out of the Evanston Center. Her specialty areas are anxiety and bipolar disorders with the interventions of Acceptance and Commitment Therapy and Dialectical Behavior Therapy.

Carla Garcia is a 27-year-old Hispanic female. Carla is bilingual and bicultural (English-Spanish). She graduated with a bachelor's degree in social work from Northeastern Illinois University in 2018. Carla joined Metropolitan Family Services as a case manager in the role of intake for our North/Evanston-Skokie Centers in 2018. In her role, Carla connects with Evanston residents, enrolls them in the programs and also provides referrals as needed at the time of intake. Recently, Carla has been accepted into the advanced standing master's degree in social work program at Northeastern Illinois University, and she will be starting in the summer of 2021.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

The average caseload for the Family Coach position will be 25 client families or less. MFS-Evanston will employ one case manager.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

The Family Centered Coaching model is an approach that focuses on the entire family and acknowledges that the family is the expert with the knowledge of what they need to overcome barriers and thrive. The model is trauma-informed and empowers client families to remove barriers by giving a choice in the services they access. The relationship is transparent and collaborative and incorporates the whole family, all with fluid goal-setting. The model understands how to improve outcomes for families, recognizing that families have certain strengths and need different services at different times to move forward. Importantly, family-centered coaching is rooted in the understanding of the institutional forces that prevent clients and their families from moving forward, including the long and persistent effects of systematic racism and poverty. The model relies on motivational interviewing to help develop goals with a specific implementation plan (measurable outcomes, strategies and timeframes).

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

The success of the Family Coach position is rooted in the support system employed to ensure the position has the personal and professional resources to succeed. Importantly, supervision of the Family Coach is paramount to the success of the position. Supervision will be held in weekly meetings for both administrative and clinical coaching.

MFS has on staff a Training Manager who provides a comprehensive calendar of activities and opportunities related to professional development. The agency uses Ultipro as its training platform, which offers a diverse group of web-based trainings for staff. Professional development -- through Ultipro -- can be customized to the individualized needs of each staff member to help achieve targeted goals for their career development. Project staff will also have access to their individualized education and career-focused pathway with achievable and advancing goals/objectives, timelines for completion and supportive services as needed through a number of MFS resources and services.

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

The components of family-centered coaching includes working with members of the family who make decisions on behalf of the family. The values of this model are: full family focus, family led, respect, strength based, and racial equity and inclusion. The Family Coach will prepare for each meeting, create motivational and open-ended questions for different content areas to understand the client's situation and will learn more about the strengths and needs of the families. The components will screen clients for needs such as safety, healthcare, housing, employment, create linkages for resources and will update the outcomes and progress in subsequent meetings. This staff member will have 40-hour training for domestic violence and will be well versed in community resources and governmental programs.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

MFS-Evanston staff will create a service plan with the client after a motivational interview and targeted questions with the client. Because family-centered coaching takes a holistic approach to working with families, there are numerous areas that may need to be addressed, organizations must work together to have the expertise to meet the needs of clients. The staff will review needs in areas where clients are seeking assistance. Content areas include: basic needs (housing, food, transportation, safety), child well-being and parenting, employment/career/education, legal, financial, physical and mental health/well-being, and family/friends/relationships. The client will answer open-ended questions related to all topics and the plan will identify the client and other family members necessary to include for services.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

The service plan is a family-centered, strengths-based document with common components including screening, needs assessment, identifying barriers and resources, budget, goals and an implementation plan. MFS has a strategy for motivational interviewing, one where clients are engaged and utilizing their strengths to achieve goals. MFS will place a priority on building a collaborative, encouraging relationship with clients and establishing trust. MFS staff are trained in trauma-informed practices and understand the importance of active listening and continued engagement. MFS staff will continue to encourage clients if they encounter a setback. With the motivational interviewing, the Family Coach will address any service plan setbacks by helping the client to understand barriers and create linkages to services that will meet their needs. An example of a service plan goal would be identifying that a family needs to be linked with Medicaid coverage. The service plan would outline the overall goal, which would be to secure the Medicaid coverage, and identify the interventions and steps that would be taken to reach that goal. The service plan also lists the client's desired goal or goals in the client's words, the client's strengths, the current supports system and the client's motivation and willingness to participate in services.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

MFS staff review service plans at least every 6 months. Service plans may be updated before 6 months based on client's needs and progress. Service plans are completed with the client and the reviews reflect the client's feelings about their progress as well as documentation of the plan for continued work with the family. Progress notes are documented in the electronic health record system after each session with the client. Notes on advocacy, linkages and referrals for the client are also documented in the electronic health record system.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

MFS-Evanston staff will engage the client in several meetings to build the relationship and to understand the holistic approach to achieving positive outcomes. Toward the beginning of the process, staff will meet more frequently (weekly, bi-weekly) with the client. As the plan starts to take shape and outcomes are achieved, meetings will be more sporadic (monthly or quarterly); however, the client can always reach out to increase the frequency of the meetings based on a current situation. For example, the Family Coach may meet intensively with a client to secure employment. Those meetings may be less frequent after the client begins work. If the client's employment situation changed again, the frequency of the meetings could increase at that time. The duration of the meetings would vary depending on the tasks that needed to be completed. The Family Coach might routinely have a one-hour session with a client; however, if the client needed to update a resume, apply for jobs or see apartments, those sessions could be longer blocks of time.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

MFS-Evanston collects client information and documentation through Smartcare, an electronic health records (EHR) system. Each registered client has intake data (purpose for seeking treatment, referral source) including client demographics, household financial information and racial/ethnic data. MFS protects the confidentiality of all program participants and will only supply information in aggregate or will remove identifying information. MFS will create and retain participant files, service plans, and records relative to each participant's engagement in the program. Participant records will include each participant's name, address, services provided, and other information relevant to the specific program being implemented. All services are documented and progress notes are recorded after each session.

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

The success of clients is as unique as each of their service plans. Graduation from case management varies according to the needs of the family: in some cases, clients may need services or referrals up to a year or more. In general, families generally would need support for about 3-6 months. MFS lets clients who are graduating from our programs know that they can always re-engage in services, if needed. This process can be completed with a phone call to our intake worker, the Family Coach or the supervisor. MFS recognizes that families may need services at different points of their lives, and MFS staff are there to meet those needs.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the barriers to receiving those services?**

The services that will be needed include the following: linkage with health insurance for adults and children; assistance with finding affordable housing, assistance with finding employment or increasing employment; assistance with finding child care; linkage with primary care physicians for adults and children; linkage with behavioral health services for adults and children; assistance with addressing basic life needs and identifying resources for housing, to address food instability, transportation, and as needed financial assistance; linkage with domestic violence services; and advocacy for children in the schools. MFS-Evanston staff report that many clients are unaware of the services available to them and their family members. Additionally, financial difficulties, language barriers, fear of accessing services, and the inability to navigate complex systems are all barriers that clients face. With knowledge and expertise, MFS staff can help families navigate services including complex enrollment systems to access services.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

The Family Coach will manage the referral process. The Family Coach will identify resources, contact internal and external organizations to check on guidelines/eligibility, give information to client, help to connect with a warm handoff process (facilitated introduction by case manager), tracked through progress notes (internal and external).

Referrals are tracked in SmartCare, the electronic health record (EHR), and through case notes. In EHR, information about the client is gathered including financial, family structure (single headed households), health concerns, language, transportation and childcare. MFS-Evanston staff report that clients often request services or assistance in accessing: mental health services, domestic violence services, food, emergency housing (rental) assistance, employment, childcare, early childhood education and advocacy in the schools.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

MFS has strong relationships with other organizations in Evanston, both formal and informal. MFS has a linkage agreement with the District 65 Family Resource Center. Informally, MFS has worked collaboratively for decades with other service providers by organizing resource fairs, and accepting referrals from other entities including the Lincolnwood Elementary School social worker, Erie Family Health Center, early childhood education, Evanston LAN 40 and Evanston Cradle to Career.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

MFS, a 501 (c) 3 not-for-profit corporation, has served Chicago and its suburban communities for over 160 years. Its mission is to provide and mobilize the services needed to strengthen families and communities. MFS uses a community-centered service delivery model, concentrating resources in over 70 communities within Chicago, suburban Cook and DuPage counties. MFS-Evanston is one of seven centers and has served the Evanston community for over 20 years.

For over 20 years, MFS has delivered an intensive, case management, clinical and education program exclusively for Evanston residents through the Family Support and Prevention Program. In 2019, MFS recognized the need to expand services to children and expanded the program to include direct services with children. Working directly with the children as well the parents has provided an additional layer of support for the families. The program addresses the mental health needs of the clients as well as linking them to services to meet basic needs, such as housing, food and medical care. By strengthening the functioning of families, the program reduces the risk that families will enter the child-welfare system due to abuse or neglect of their children. Participating clients receive individual/family counseling, advocacy and case management. Parents are supported in learning more effective parenting skills and in creating a stronger home environment with improved family dynamics. Interventions are based on the Centers for Disease Control's (CDC) research reflecting program components essential for effective service delivery for families at risk of abuse and neglect.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

MFS has the capacity to manage federal funds, including record keeping, eligibility of uses and other fiscal and administrative controls.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

MFS-Evanston evaluates program performance and monitors customer satisfaction by conducting a quarterly customer satisfaction survey. The survey mirrors items that are reflected in the National Consumer Satisfaction Surveys: feeling welcome within the program setting, staff responsiveness to client needs/progress; staff speaking to clients in a way they understand; staff being respectful of cultural and ethnic backgrounds, religious values, and spiritual needs. If concerns are raised on a survey and not expressed by clients to staff directly, the supervisor addresses global strategies to improve program components. Clients are also offered the opportunity to share their stories on the MFS website, in brochures, MFS Events and Celebrations, in social media and annual reports. They are able to share how case management counseling, support groups, and referral services have helped them get through challenges, improve their health, and locate available resources in the community.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

The staff of the agency is reflective of the communities served. Of the 1,211 MFS employees, 76% are women, 33% are Latinx/Hispanic and 35% are Black. The executive leadership team is made up of 13 professional staff: the CEO, COO, CFO, VP of Human Resources, VP of External Affairs, the Executive Director of Legal Aid Society, Executive Director of the Metropolitan Peace Initiative and the Executive Directors of MFS's North/Evanston Skokie, Calumet, Southeast, Southwest, Midway and DuPage community centers. Of these 13 leaders, seven are staff of color (54%) and eleven are women (85%).

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

79745246

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

Yes

No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

IF "YES," ENTER "NA."

NA

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

MFS-Evanston office, home-based visits, community location, virtual (phone or Zoom)

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.

## Budget [top](#)

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Funding Request	USD\$ 72,270.00	USD\$ 45,000.00	
Metropolitan Family Services Fund Raising/Unrestricted	USD\$ 50,662.00	USD\$ 46,090.00	
Finnegan Foundation		USD\$ 66,667.00	
<b>Total</b>	<b>USD\$ 122,932.00</b>	<b>USD\$ 157,757.00</b>	<b>USD\$ 0.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
City of Evanston Funding Request		USD\$ 45,000.00	USD\$ 0.00
Salaries	USD\$ 67,287.00	USD\$ 49,080.00	USD\$ 36,000.00
Fringe Benefits	USD\$ 15,483.00	USD\$ 11,941.00	USD\$ 9,000.00
Program Expenses	USD\$ 1,250.00	USD\$ 1,000.00	
Staff Mileage	USD\$ 1,450.00	USD\$ 566.00	
Professional Fees	USD\$ 10,675.00	USD\$ 666.00	
Staff Supplies	USD\$ 2,212.00	USD\$ 317.00	
Technology/Telecommunication	USD\$ 2,540.00	USD\$ 5,251.00	
Occupancy	USD\$ 7,425.00	USD\$ 18,541.00	
Other	USD\$ 1,713.00	USD\$ 2,426.00	
Administrative	USD\$ 12,897.00	USD\$ 22,969.00	
<b>Total</b>	<b>USD\$ 122,932.00</b>	<b>USD\$ 157,757.00</b>	<b>USD\$ 45,000.00</b>

## Budget Narrative

The MFS fiscal year is July 1 - June 30. The expenses above are based on a 6 month grant. City of Evanston funds will be used to support the salary of a 1.0 FTE Family Coach. The breakout will be approximately \$36,000 in salary with the remaining \$9,000 to cover benefits and related expenses. The Family Coach position has been posted and is in the

hiring process. Funded staff positions will serve Evanston clients exclusively.

MFS has a full time External Affairs staff who organize fundraising campaigns, events, and planned giving as well as seeks grants through private grant sources. The proposed budget includes funding from the Finnegan Foundation to supplement the start-up of this new program. Additional funding for the program will be provided by Metropolitan Family Services' fundraising and unrestricted revenues.

**Program Outcomes** [top](#)

**Program Outcomes**

	Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
1	Case management needs will be identified for all enrolled clients.	Needs will be documented on a service plan in the EHR system.	0	30	30			0
2	Clients will receive referrals and be linked to services in Evanston.	Referrals and outcomes will be documented in progress notes in the EHR system.	0	30	30			0
3	Clients will show progress in one or more areas of case management.	Progress will be documented during service plan reviews every 6 months, and progress will be documented at the time of discharge.	0	24	24			0
4					0			0
5					0			0
<b>Total</b>			<b>0</b>	<b>84</b>	<b>84</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Program Line Item Expenditures**

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

**Program Line Item Funding**

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0

2						\$ 0
3						\$ 0
4						\$ 0
5						\$ 0
6						\$ 0
7						\$ 0
8						\$ 0
9						\$ 0
10						\$ 0
11						\$ 0
12						\$ 0
13						\$ 0
14						\$ 0
15						\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

**Documents** [top](#)

**Documents Requested \***

Required? **Attached Documents \***

REQUIRED FOR ALL EXTERNAL APPLICANTS. Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.



[MFS 2020 Audit](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS. Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

[2020 Annual Report](#)

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).



[IRS Determination Letter](#)

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.



[StaffBios](#)

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

Supplemental information relating to your program or agency, as applicable.

Form used to document income of participants to establish eligibility.

[Income Verification](#)

HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Policies/procedures for case management process and case file documentation/maintenance.

[Case Files Documentation](#)

[Case Files Documentation 2](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS. Chart of Accounts used to define each class of items



[Chart of Accounts](#)

for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).



[RevExpend](#)

Organizational commitment to equity, diversity and inclusion.

[REIJ Action Plan](#)

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[OperatingBudget](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

[MFS 2021 Board](#)

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form.



[Signed Disclosure](#)

[download template](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.



[Signed Duplication of Benefits](#)

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Application ID: 349012

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## North Shore Senior Center FY 2021 Case Management Services

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 30,000.00** Requested

Submitted: 4/21/2021 2:51:24 PM (Pacific)

### Project Contact

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Tish Rudnicki  
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## Application Questions [top](#)

### 1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?

Care coordination/case management is the foundation of North Shore Senior Center's (NSSC) community-based services. The Center provides supportive counseling and case management services to Evanston seniors, people with disabilities and their families.

The majority of older adults we serve in Evanston are low income and need emotional support and/or counseling, assistance maintaining their financial security or their access to public benefits and need help in order to preserve or improve their health and well-being. Living life at or below the poverty line presents significant challenges for older adults, and those challenges can be overwhelming. The Center's programs are designed to provide opportunities for socialization, avoid isolation and help seniors navigate the challenge of remaining in their homes.

The Senior & Family Services department represents more than two-thirds of the services North Shore Senior Center provides to older adults. North Shore Senior Center is the only agency designated by the Illinois Department on Aging as the Care Coordination Unit (CCU) for its Community Care Program for New Trier, Niles, Northfield, Maine Townships and the City of Evanston. CCUs have designated areas and do not overlap.

North Shore Senior Center receives calls for services from a variety of sources in the Evanston area including: City of Evanston, Levy Senior Center, community partners such as Open Communities, Meals at Home, homemaker agencies, hospital discharge planners, local police, clergy or family and friends of the resident in need of services. Approximately 40% of new clients are referrals. The largest number of referrals are received from local hospitals, homemaker service agencies, individuals seeking services or family members calling for information on their behalf.

### 2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.

North Shore Senior Center specializes in providing person-centered programs and services for all older adults, offering a full range of opportunities supporting healthy aging to them and their families with community-based services. NSSC provides services to adults of all ages, races, ethnicities, religious traditions and spiritual practices, genders and sexual orientations.

NSSC staff will continue to engage underrepresented populations by offering a broad array of supports accessed through the umbrella of case management.

Health equity can be created within the social determinants of health for low-income seniors, providing stability and improving health outcomes, which allows them to live independently and age in place. We will strive to increase racial equity through enhancements and focused recruitment of new older adult participants of all backgrounds within the Evanston community by utilizing and further developing existing partnerships. We will work with the City of Evanston, nonprofit partners and the faith-based community to recruit Evanston residents in need of services.

According to a Brief issued in May 2018, from the AARP Foundation and Impaq International, social determinants of health (SDOH) encompass the social, economic and environmental factors that can affect individuals' health and quality of life. SDOH can include adequate access to food/nutrition, income, transportation and housing. Individuals whose basic needs are met are more likely to maintain better health; this is especially true for older adults. SDOH can significantly impact a senior's ability to live independently in their community of choice. With focused attention health equity can be improved by addressing SDOH for low-income seniors, providing stability and improving health outcomes. This process starts by assessing need and ensuring the appropriate benefits and supportive services are in place. Funding from this grant is important to NSSC because it will enable us to hire a part-time Evanston coordinator to assist our current care coordinator with care management. The extra staff member will help us increase our outreach efforts in the community.

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

No one is turned away for services and none of the programs and services we provide to Evanston residents have a wait list.

**4. Does demand fluctuate throughout the year? If so, please explain.**

The demand for services is relatively consistent. Fluctuations can occur when there are changes in the services offered by certain agencies (i.e. LIHEAP shut-offs). Requests for caregiver respite increase in during the summer and holidays.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

The target population for our program is low-income seniors and people with disabilities residing in Evanston who need help accessing social services programs. The seniors served are adults age 60 and over and their families. Some 66% are frail or disabled, 45% live alone, and 7% have limited English-speaking skills. A further breakdown of their race /ethnicity shows 56.4% White/Non-Hispanic; 0% White/Hispanic; 38.4% Black-African American/Non-Hispanic; 0.1% Black-African American/Hispanic; 4.6% Asian/Non-Hispanic; 0.2% Islander and 0.2% other. Gender breakdown is male 33% and female 67%. The family status of our participants is 23% single; 20% married; 1.5% separated; 10% divorced; 25% widowed and 0.3% living with a domestic partner. Over 90% of our clients live between the poverty line and low-income levels and do not have the funds for basic necessities. Their economic status is as follows: 14.9% of clients are very low income; 6% of clients are low income; 3% of clients are moderate income.

Some programs have income guidelines. We determine low-income levels by following the federally established guidelines as listed on the 2021 National Aging Program Information Systems (NAPIS) intake form, which identifies poverty-level income as \$0 to \$12,880 and low income as \$32,651 to \$52,200. For means-tested services, clients are asked to state their incomes and assets. The information is verified through the client's bank account records, tax returns, Social Security income statements and other documentation.

NSSC offers home and community-based services that support independent living. Living at or below the poverty line presents significant challenges for seniors. The services NSSC provides help seniors remain independent and in their own homes so they do not have to be placed in skilled nursing facilities which can be devastating for both the client and their family. For many clients, English is a second language, employed are case managers who speak Assyrian, Spanish, Russian, Chinese, Urdu, Mandarin Chinese, German, and Romanian to help insure effective communication. Translators for other languages are provided when needed.

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

<input type="text" value="21,715"/>	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
<input type="text" value="2,115"/>	Unduplicated Evanston residents to be served in 2021	
<input type="text" value="17,115"/>	Unduplicated low/moderate income people to be served in 2021	
<input type="text" value="19,831"/>	Unduplicated people served in 2020	

1,928	Unduplicated Evanston residents served in 2020
15,628	Unduplicated low/moderate income people served in 2020
1,739	Unduplicated low/moderate income Evanston residents served in 2020
80,071.00	<b>TOTAL</b>

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

As of January 1, 2021, 928 Evanston case management participants were enrolled. NSSC expects to enroll 100 new Evanston case management participants by December 31, 2021.

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

Twenty-one professional staff members provide services in the Niles/Evanston Senior and Family Services offices. Included in this group are nine Care Coordinators, one Caregiver Specialist, one Older Adults Benefits Specialist, three Clinical Supervisors, three Determination of Eligibility Coordinators, one Case Aide, one Receptionist and one Director. All care coordinators have a minimum of a bachelor's degree and most have master's degrees and clinical licenses.

Sharon Stoltz, Evanston Senior Services Coordinator works exclusively with Evanston clients. Sharon joined NSSC a year and a half ago. She has bachelor's degree in Social work from Loyola, Chicago and her Master of Divinity from McCormick Seminary, Chicago. Sharon responds to information and referral Inquires from older adults and/or their families in Evanston, particularly as it relates to helping individuals access public benefit programs and serves as a co-facilitator for the Grandparent Raising Grandchildren Program and runs the program's once-monthly support group. This position is not contingent on city funding, however should NSSC receive funding, Sharon will be able to focus more of her time on care management using the services mentioned above.

An Older Adults Benefits Specialist works at the Evanston Civic Center office twice a week helping Evanston residents apply for and maintain public entitlements and other benefits. Individuals are screened for their eligibility for 20 different programs that provide money or services. Lynda Korsah, Older Adult Benefits Specialist has been with NSSC since February 2021. She earned her Master of Science in Urban Planning and Policy from Rutgers and her Master's in Public Health with an in interest in Community Health and Gerontology from the University of Illinois at Chicago. The Older Adults Benefits Specialist's position is not contingent on City funding.

Funding from this grant will allow North Shore Senior Center to create a new part-time position for a case management assistant who will provide much-needed support exclusively in the Evanston office. In addition, NSSC supports the salaries and benefits for other care coordinators working with Evanston residents, the Caregiver Specialist and other staff members who provide services to Evanston residents.

NSSC received a five-year accreditation from the National Institute for Senior Centers in August 2019 and a three-year accreditation from CARF International in April 2021.

Demographics for the primary NSSC staff working with Evanston residents is:

Ages: 25-29 (8), 31-39 (4), 40-45 (3), 54 (1), 61-65 (4), 72 (1)

Gender:

Male: 5% Female: 95%

Ethnicity/Race:

Hispanic or Latino 5%

Asian: 10%

Black-African American 10%

White: 75%

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

Evanston is served by nine coordinators, one dedicated to Evanston residents who require the highest level of care. Her caseload averages 75 older adults. Eight Niles office coordinators average 16.5 older adult Evanston residents.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

Throughout the organization, NSSC promotes a person-centered approach, which considers the whole person and each individual's unique qualities, abilities, interests, preferences and needs. The World Health Organization defines person-centered care as "empowering people to take charge of their own health rather than being passive recipients of care." At

NSSC, it is the goal of the care coordinator to create an interaction with the client that is more personal than transactional. This strategy is advantageous for both the care coordinator and the client and can improve overall health outcomes and service goals.

Other methods employed by our care coordinators to help establish a trusting relationship and rapport with the client is motivational interviewing and participant informed goal setting. While working with clients and throughout the assessment and service plan process, care coordinators listen to the client, assume a nonjudgmental stance and seek to understand the person's perspectives and experiences. This approach shows respect for the participant's right to make informed choices about their own care. This comprehensive, personal approach helps the client become an active participant in their own care, which in turn will yield better long-term results.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

NSSC recently received a full CARF Accreditation for the seventh time, valid through April of 2024. This accreditation acknowledges NSSC's commitment to CARF's comprehensive standards, including those related to training and professional development. A copy of the Staff Training Documentation with the CARF standards is attached. This form is included as a part of each employee's 90 day and annual review. The training requirements as set forth by CARF, are specific to an employee's role.

In addition, the Illinois Department on Aging (IDoA) mandates that each care coordinator be certified by the state and requires an initial and an annual training in pertinent topics such as Suicide in Older Adults, Social Determinants of Health and Impact of COVID-19. IDoA also provides educational tools for provider agencies like NSSC and the Aging Network. When the trainings can be presented in-person, they may offer continuing education credits for the following: Nursing Home Administrators, Licensed Social/Clinical Social Workers, Clinical/Professional Counselors and Licensed Practical Nurses/Registered Professional Nurses. All care coordinators are encouraged to attend these trainings regularly.

Because NSSC's single most valuable asset is its employees, their professional development and ongoing education is of paramount importance. The organization uses both internal expertise, virtual tools like an extensive menu of training options provided by ADP, and offers no less than two CEU programs a month, presented by experts in various related fields. Training opportunities are also offered on a wider scale to staff and the community and arranged by the Center's Diversity Committee and Lifelong Learning Department. Collaborating to address issues across the organization and to provide targeted training as the Center continues to address issues of equity, privilege and inclusion, a sample of recent training topics includes:

- 6/10/20 – Racial Justice – NSSC's Diversity Committee
- 6/30/20 – What Do You Mean Race is a Social Construct – Dr. Durene Wheeler, Ph.D., Educational Inquiry and Curriculum Studies, African and African American Studies, Northeastern University
- 9/2/20 - COVID19 & Privilege: Shared Pandemic/Different Realities – NSSC's Diversity Committee
- 2/23/21 – Social Justice in Practice: Mitigating Bias & Understanding Privilege- Tobias Spears, Assistant Dean & Senior Director, Diversity & Inclusion, University of Chicago

The following are offered by Lifelong Learning to staff and the community:

- Compounding Harm: Racism and the Drivers of Mass Incarceration of African Americans (a panel discussion with former inmates and ambassadors of the Illinois Prison Project)
- The History of Islam
- Never Caught: The Washingtons' Relentless Pursuit of Their Runaway Slave – An Eye-Opening Look at Slavery During the Founding of America
- Voter Fraud and Suppression: The Fight Over Voting Rights

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

Obtaining services for older adults usually begins with a call to North Shore Senior Center. Intake is the central point of entry and the intake specialists have a deep understanding of the intricacies of making appropriate referrals. If a family member is making the initial inquiry, the intake specialist will engage the caller and try to establish a rapport with the family member so they are comfortable entrusting the care of their loved one to NSSC. Occasionally, a need is met and addressed during the initial phone call. When the intake specialist is unable to resolve the caller's issue, the client is assigned to a care coordinator who becomes the liaison connecting the senior to appropriate services. The intake and case assignment process can take up to an hour to complete.

Once a care coordinator has been assigned, they will contact the client to confirm they want services and to set up an appointment to meet with them to complete a comprehensive needs assessment from which a person-centered care plan is

developed and then implemented.

The person-centered plan is created after NSSC's care coordinators administer the State-required comprehensive needs assessment. The assessment evaluates a senior's ability to perform activities of daily living and instrumental activities of daily living. It also evaluates the older adult's mental status, medical conditions, nutritional status, social support system, access to transportation, spiritual support, as well as financial and legal needs. The assessment is normally done in the home, allowing the care coordinator to make a visual assessment of the environment so they can recommend measures to enhance client safety and access. During the pandemic, all case assessments have been conducted telephonically to maintain safety standards mandated by the state.

The comprehensive assessment and development of a service care plan can take up to two hours to complete.

Once the service plan is in place, the care coordinator will follow-up with the client to monitor their progress and make changes or adjustments to the services, as needed. After every conversation or meeting with the client, case notes are updated and electronically filed. Because the person-centered plan is specific to each client and tailored to their needs, the frequency and duration of the calls/visits will vary from client to client.

The client is not obligated to accept services. If a client chooses not to receive services after the completion of the assessment, they are informed how to reach NSSC in the event they change their mind and want to receive services at a later date.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

The service plan is developed after an extensive person-centered assessment has been completed with the client. Because the process is comprehensive, the care coordinator will have a good sense of what services will be a part of the plan by the end of the client interview. Once the coordinator has developed the plan, it will be presented and discussed with the client and the client will select the services options they want to use.

The documents requested will depend on the services needed. Some community resources have specific age, income, asset or other eligibility criteria and documents will be required to establish that criteria. As a general rule, once a client has been assigned to a care coordinator, they are asked to provide an official form of identification and a social security number. This information is used to verify their identity and provide NSSC with their former case and services history. Other requested documents may include financial papers, proof of insurance, Medicare card or proof of supplemental insurance. Whether additional documents are required will be established during the comprehensive client assessment process.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

The care coordinator develops a person-centered plan and assesses the client's capabilities to create a plan that matches those needs. Once the resources for those needs have been determined, the coordinator can set-up the services for the client or they can work with the client and/or family to get everything in place.

During the comprehensive assessment meeting, the care coordinator will identify the client's specific needs. Domains of care used during this process can include one or more of the following issues: socialization, legal status, caregiver needs, financial concerns, availability of transportation, need for a nutritional screening, medication review, behavioral and/or physical health status, functional impairment challenges and spiritual needs. Using motivational interviewing and participant informed goal setting, the care coordinator can determine the strengths and weaknesses in each of the domain categories as they apply to a particular client. In conversations with the client, they can develop a service plan that is person-centered and need specific for that client.

Typical outcomes can vary based on identified needs. For example, if there is an identified need expressed in the nutrition domain, then a typical outcome would be implementation of home delivered meals, food pantry or SNAP application completion. If there is an identified need in the functional impairment domain, then a typical outcome would be implementation of homemaker services through the Community Care Program or Chore Housekeeping program.

Progress toward achievement of goals is tracked through regular contact with the client and documented in the case notes. Success is measured by client satisfaction surveys, goal review and an annual assessment evaluates the individual client's needs and look at whether those needs were met.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

Each North Shore Senior Center program has an established set of goals and objectives which are evaluated whether those goals/objectives can be achieved effectively. Individual client progress notes are documented as soon as possible after a client meeting or conversation and the staff monitors a client's progress by using a customized software developed to electronically track client information and produce outcome reports. Clients and their families are surveyed on an annual or biannual basis to

rate their level of satisfaction with the programs in which they participate. A case can be reassessed at any time if requested by the client, the family or a healthcare worker.

In the Senior and Family Services department, separate goals and indicators are established for the different social service programs. Success in meeting these goals is determined by the number of people served; a review of cases to verify individual needs were met; analysis of satisfaction surveys and reports from outside evaluators such as AgeOptions and the State of Illinois.

Many programs such as the Adult Protective Services program have their own unique indicators. Success is determined in two ways: 1) our ability to meet the time frames in which reported cases are investigated; and 2) establishing the risk level of clients who are substantiated victims of abuse and accept services will not have increased at the time of case closure for at least 95% of clients served.

In addition, NSSC's strategic plan has numerous action objectives used to measure organizational success. Our Board of Directors monitors implementation of these objectives.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

Care coordination services provide seniors with the ability to continue to live independently in their community, connected to their family, friends, clubs and other organizations. The wide spectrum of services includes information and assistance, support groups, access to home delivered-meals, benefits access and more. The care coordinator identifies needs, develops a care plan and arranges for services. The coordinator continues to work with the participant to develop, implement and monitor a person-centered plan of care.

The majority of older adults receiving services also benefit from emotional support provided by the care coordinator and ancillary providers like the Benefits Specialist or from participation in one of NSSC's support groups. NSSC's care coordinators are able to access a wide array of programming and services offered across the organization, as well as those offered by community partners. This allows us to provide the most comprehensive care possible while always being mindful of our mission, "To foster the independence and well-being of older adults, enhance their dignity and self-respect, and promote their participation in and contribution toward all aspects of community life." Because caregivers are often integral to an effective service plan and may also need support, NSSC offers services, groups, education and counseling designed specifically to meet their identified needs. The success of a service plan often relies on strong, committed caregivers, fostering them goes hand-in-hand with case management for the older adult.

In Evanston specifically, the vast majority of cases the Senior Services Coordinator handles are intensive care management clients whose needs require a higher degree of assistance and follow-up to insure they are able to manage and reach the goals and objectives outlined in the assessment and established as part of their service plan. Intensive care management clients typically require a wider spectrum of services over an extended period of time. Two examples of intensive care management client stories are attached.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

All NSSC care coordinators are required to create written case notes documenting any conversation or visit with a participant receiving social services. The case notes are entered into an electronic integrated case management system (CDS). Every time entry must contain a corresponding case note. Concise, clear and objective case notes should be entered into the system as soon as possible after contact with the client. The case notes should describe what the case manager did, any decisions or actions taken, reasons for any decisions and plans for future action. Relevant statements made by participants and/or family members should also be recorded. In addition to the case notes, case records contain all documentation related to the client case. Examples of additional documentation include: the annual comprehensive assessment, copies of completed applications or forms, Release of Information forms, faxes and emails and other relevant written correspondence. An example of documented case record/notes is attached.

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

All client cases are assessed annually but can be reassessed at any time if requested by the client, the family or a healthcare worker. Intensive case management clients rarely "graduate" from the program. Because their needs are greater and require management over a more extended period of time, the goal is to stabilize the client and help them maintain so they can remain in their homes and continue to be a part of their community. Occasionally, a client will be transferred to an assisted living facility. To ease the adjustment of this move for the older adult, NSSC will work cooperatively with the facility and the family.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient.**

### **What are the barriers to receiving those services?**

NSSC is the only organization designated by the Illinois Department on Aging as a Care Coordination Unit (CCU) under its Community Care Program in the City of Evanston. CCUs have designated areas and do not overlap. NSSC is the only agency that can administer the state-required comprehensive 21-page needs assessment in our service area. This assessment is an integral part of determining and setting up the services needed by seniors. It evaluates a senior's ability to perform activities of daily living and instrumental activities of daily living. It also evaluates the person's mental status, medical conditions, nutritional status, social support system, access to transportation, spiritual support and financial and legal status. The assessment is done in the home, allowing our care coordinators to make a visual assessment of the environment and recommend measures that may enhance client safety and access.

Examples of our programs include:

- Older Adults Benefit Program: Provides trained volunteers to assist seniors in applying for and maintaining public entitlements and other benefits.
- Chore Housekeeping: Provides trained housekeepers to assist seniors by doing light housekeeping several hours each month.
- Home Delivered Meals Program: Links seniors living alone to meal providers so that they can enjoy healthy, nutritious food in their own homes.
- Support Groups: Offers a variety of groups, free of charge, to clients, their families and their caregivers. They include low vision, Parkinson's disease, hearing loss, Alzheimer's disease and caregiver support.
- Escorted Transportation Services: Arranges rides for seniors to/from medical and dental appointments.
- Choices for Care: Ensures that individuals who are planning to enter a nursing facility actually need that level of care and are aware of the options/community resources available.
- Health/Wellness Program: Held in four Evanston rent-subsidized buildings; educates clients using evidenced-based presentations on how to effectively communicate with health providers.

In March of 2020, COVID-19 forced NSSC to close its doors; this unprecedented decision was made to ensure the safety of participants, their families and staff.

Quickly, NSSC staff developed new ways to provide support, address social isolation and meet the needs of older adults during this difficult time. Undaunted by this new barrier to services, NSSC continued to fulfill our mission to serve older adults and their families by providing services telephonically when directed by state guidelines to do so, reaching out to all connected to NSSC be they clients, program participants or volunteers with regular well-being checks, arranging emergency services for community members in need and creating a robust variety of virtual programming spanning the scope of previous in person programming.

### **20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

North Shore Senior Center offers many different program options, and we often refer within the organization to ensure that client needs are met in the most effective way. If the Senior and Family Services Department is working with an individual that identifies mental health needs, a referral can be made to North Shore Senior Options Behavioral Health. If Senior Options identifies someone needing assistance with caregiver resources, a referral can be made to Senior and Family Services.

Referrals can be made in one of two ways: we can transfer phone calls from one department to another or, with proper client consent, staff members can refer clients from one department to another. North Shore Senior Center also makes referrals to outside service organizations when clients present with needs that are beyond our areas of expertise or beyond our service area. We document referrals in client records. Any follow-up done on referrals is also documented in the case notes.

### **21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

NSSC has a MOU with Open Communities and maintains contracts with CEDA and Age Options. Community partnerships include the City of Evanston, Evanston Hospital, St. Francis Hospital, Glenbrook Hospital, Holy Family Medical Center, Skokie Hospital, Lutheran General Hospital, Meals on Wheels, CJE Senior Life, Evanston Public Schools, Faith in Action, SHIP, Impact Behavioral Health, Levy Senior Center, Argentium & Senior Connections, Family Focus, Legal Aid Chicago, Second Sense and Connections for the Homeless.

Regular referrals are made to a variety of agencies to support Evanston residents. Working together with Connections for the Homeless, NSSC helps seniors remain in their homes or relocate appropriately. We collaborate with Second Sense who supports seniors with low vision. We also refer clients and collaborate with CEDA for the LIHEAP program, SHIP, CJE Senior Life, Open Communities, Senior Connections, Faith in Action, Family Focus Legal Aid Chicago and various churches and synagogues.

NSSC's Niles/Evanston offices collaborate with the City of Evanston to conduct various programs and services at the Levy Senior Center as well as other municipal sites. In addition, we administer the Senior Farmers' Market Nutrition Program in collaboration with the City of Evanston, the Village of Skokie, and CJE Senior Life and we distribute coupons to multiple Evanston subsidized senior residential buildings.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

Founded in 1956, NSSC is a 501(c)(3) organization whose mission is to foster the independence and well-being of older adults, enhance their dignity and self-respect, and promote their participation in and contribution toward all aspects of community life. In 1996, NSSC opened an office in Evanston when it was awarded a contract to facilitate the Community Care Program (CCP) for 300 clients. In 1998, the Grandparents Raising Grandchildren (GRG) program was initiated in Evanston because a growing number of grandparents had assumed the responsibility of raising their grandchildren and no other support was available to serve the needs of these families. In July 2017, we started PEARLS (Program to Encourage Active and Rewarding Lives for Seniors) to provide home-based therapy for low-income Evanston residents with signs of depression.

As the need for services increased, our office space in Evanston no longer met our needs and necessitated a move to a larger space in Niles in March 2016. To maintain our presence in Evanston, we staff an office in the Evanston Civic Center where our Senior Services Coordinator provides case management to residents, responds to 311 callers, provides community education programming, serves as a liaison to the City of Evanston and other community groups. An Older Adults Benefits Specialist and a group of dedicated volunteers also provide benefits counseling to Evanston residents.

In March 2020, COVID-19 forced NSSC to close its doors to ensure the safety of participants, their families and staff. Addressing social isolation and its related issues, caregiver stress and loneliness became our unanticipated priority and required NSSC to redesign many established in-person programs and provide support telephonically and virtually. In the last year, NSSC reached out to clients, members, program participants and volunteers with regular well-being checks. Staff arranged emergency services for community members in need and created virtual programming which spanned the scope of previous in-person programming. As restrictions allowed, NSSC offered drive-thru events: Senior Farmers Market Coupon and GRG Back to School and Holiday Party pick-ups.. These resources and financial support coupled with face-to-face interaction provided much needed socialization and emotional support.

NSSC is governed by a 26-person Board of Directors with oversight by Executive Director Tish Rudnicki. Our leadership team includes department directors from Lifelong Learning, Development, House of Welcome Adult Day Services and Senior Options, Senior and Family Services, Facilities/Operations and two associate directors from Human Resources/Volunteer Services and Marketing and Communications. Our goal as an organization is to assure financial stability; develop strategic marketing initiatives; attract and retain the highest quality board members, staff and volunteers; explore expansion and contraction; and maintain a commitment to excellence.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

NSSC has a written procurement policy which outlines requirements of purchases below \$3,500, purchases between \$3,500 and \$150,000, and purchases above \$150,000 in compliance with 2CFR, Part 200.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

NSSC administers two surveys: one in January which is directed toward clients who have received Information and referral services. It asks about client satisfaction and accuracy of referrals; the second survey is directed toward professional referral sources and asks about response times and customer service. A survey is also set to all LIHEAP and SHIP benefit clients.

North Shore Senior Center also has a policy to address Feedback from Persons Served. The policy and feedback forms are posted in all NSSC locations. In addition, every client is supplied with a notice of privacy practices when their assessment is complete. The notice describes the client's rights as well as instructions for filing complaints. A copy of the Feedback from Persons Served is attached.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

The North Shore Senior Center recognizes that the areas we serve outside of Evanston (i.e. in Niles, Morton Grove and Skokie) do not include as many underserved residents as Evanston. As an agency, we are aware of, and are addressing, issues related to diversity.

Our board consists of 25 members – and one of color. NSSC bylaws allow the board to have a maximum of 29 members; recruiting and engaging strong, committed board members is an on-going process, NSSC is currently going through a board consulting process that is focusing on governance, engagement and creating a more diverse board.

The leadership team consists of 9 people, including one person of color – or 11.1%. This percentage also reflects the population we serve – though not necessarily the population we serve in Evanston. Each member of the team is highly regarded, respected and valued.

Our employee population is more diverse:

- 9.8% male
- 90.2% female
- 2% two or more races
- 3.9% Hispanic or Latino
- 4.9% Asian
- 10.8% Black of African American
- 78.4% White

Building and maintaining a professional, diverse, highly qualified staff has always been and remains a priority. Since the hiring of Executive Director Tish Rudnicki in January of 2019, the organization has redoubled its efforts to focus on the long-standing core value to “Embrace Diversity.”

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization’s DUNS number in the space below. If you do not already have a DUNS number, enter “NA.” All organizations receiving funds are required to have a DUNS number. Please enter your organization’s DUNS number in the space below. If you do not already have a DUNS number, enter “NA.”**

DUNS #131214538

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

- Yes
- No

**28. If “no,” explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization’s experience making such accommodations.**

IF “YES,” ENTER “NA.”

NA

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

Our Evanston office is located in the Evanston Civic Center. Clients use the City of Evanston subsidized taxi, CTA #93 or the Purple Line. Our Niles office is at 7900 Milwaukee Avenue and clients take the CTA #208 to CTA #270.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

Lori "Tish" Rudnicki, Executive Director

**Budget** [top](#)

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Funding Request	USD\$ 35,000.00	USD\$ 30,000.00	USD\$ 30,000.00
Illinois Dept. on Aging CCP	USD\$ 1,300,000.00	USD\$ 950,000.00	
Government Support	USD\$ 330,000.00	USD\$ 195,000.00	
Corporations, Foundations & Organizations	USD\$ 60,000.00	USD\$ 75,000.00	
Contributions	USD\$ 105,000.00	USD\$ 235,000.00	
<b>Total</b>	<b>USD\$ 1,830,000.00</b>	<b>USD\$ 1,485,000.00</b>	<b>USD\$ 30,000.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
City of Evanston Funding Request			
Salaries	USD\$ 1,060,000.00	USD\$ 850,000.00	USD\$ 30,000.00
Payroll Taxes	USD\$ 84,800.00	USD\$ 68,000.00	
Payroll Fringes	USD\$ 127,200.00	USD\$ 102,000.00	
Professional Fees	USD\$ 80,000.00	USD\$ 88,000.00	
Printing	USD\$ 6,000.00	USD\$ 4,000.00	
Food	USD\$ 3,600.00	USD\$ 4,000.00	
Telecommunications	USD\$ 5,600.00	USD\$ 7,500.00	

Postage	USD\$ 48,000.00	USD\$ 4,800.00	
Occupancy	USD\$ 89,000.00	USD\$ 115,000.00	
Local Transportation	USD\$ 14,000.00	USD\$ 14,000.00	
Assistance	USD\$ 48,000.00	USD\$ 65,000.00	
Training & Dues	USD\$ 5,800.00	USD\$ 4,400.00	
Equipment, Rent & Repair	USD\$ 13,600.00	USD\$ 10,000.00	
Indirect Expenses	USD\$ 273,600.00	USD\$ 135,000.00	
Supplies	USD\$ 14,000.00	USD\$ 13,300.00	
	USD\$ 0.00	USD\$ 0.00	
<b>Total</b>	<b>USD\$ 1,873,200.00</b>	<b>USD\$ 1,485,000.00</b>	<b>USD\$ 30,000.00</b>

**Program Outcomes** [top](#)

### Program Outcomes

	Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
1	85% of Evanston open case management and CCP program clients receiving supportive services will remain in independent living environments	# of nursing home placements for Evanston clients and # of open clients that live in Evanston	200	200	400			0
2	Implement four outreach events to under-served wards in Evanston	# of outreach events completed	1	3	4			0
3	Based on contacts made at outreach events, 30 new people will be engaged in some level of service from NSSC	# of new Evanston residents in contact with Senior & Family Services	10	20	30			0
4					0			0
5					0			0
<b>Total</b>			<b>211</b>	<b>223</b>	<b>434</b>	<b>0</b>	<b>0</b>	<b>0</b>

### Program Line Item Expenditures

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0

<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>
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## Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Documents [top](#)

#### Documents Requested \*

REQUIRED FOR ALL EXTERNAL APPLICANTS. Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.

REQUIRED FOR ALL EXTERNAL APPLICANTS. Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

Supplemental information relating to your program or agency, as applicable.

Form used to document income of participants to establish eligibility.

HUD Family income limits used to determine

#### Required? Attached Documents \*

✓ [Audited Financial Statement](#)  
[Form 990](#)

[Annual Report](#)

✓ [IRS Letter](#)

[Affirmative Action Statement](#)

✓ [Leadership Bios](#)

[Strategic Plan](#)  
[Staff Training Evaluation](#)

[NAPIS Form](#)

eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Policies/procedures for case management process and case file documentation/maintenance.

[Case Management Policy](#)

[Documentation Policy](#)

[Sample Case Notes](#)

[Intensive Care Management Client Stories](#)

[Feedback from Persons Form](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS. ✓

Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.

[Chart of Accounts](#)

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

REQUIRED FOR ALL EXTERNAL APPLICANTS. ✓

Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).

[Statement of Activities](#)

Organizational commitment to equity, diversity and inclusion.

[Affirmative Action Statement](#)

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget. ✓

[Operating Budget](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

[Board of Directors](#)

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form. ✓

[Conflict of Interest](#)

[download template](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form. ✓

[Duplication of Benefits](#)

[download template](#)

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Application ID: 350922

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## Shore Community Services, Inc. Residential & Home Based Services

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 30,000.00** Requested

Submitted: 4/21/2021 2:52:15 PM (Pacific)

### Project Contact

Mary K. Matz, CFRE  
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### Additional Contacts

*none entered*

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### Chief Executive Officer

India Alexis Ehioba, MNA, CFRE  
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## Application Questions [top](#)

### 1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?

Individuals and families with children with intellectual and other developmental disabilities enroll in our case management to receive services to assist them in being as independent as possible and to live integrated in the least restrictive environment. Shore has a long history of working with this population that is often considered very vulnerable and has at times have been excluded because of their disability. Since a disability is life-long, many individuals will require on-going support services to maintain their level of functioning.

Shore's programs are set apart from others because we provide a variety of residential settings that are well maintained to meet individual needs including: 24-hour staff assisted residential options - two 12 bed facilities (group homes), one 7-bed, one 6-bed and one 3-bed Community Integrated Living Arrangement (CILA); Supported Living Arrangements (SLA) for individuals that can live independently include: the Patricia Lloyd Townhomes (PLT), and scattered-site apartments and condos where individuals live independently and receive intermittent staff assistance. The PLT is unique in the respect that residents have their own units; their rent is extremely affordable through a subsidy received from Shore, additional support is provided with their rent, and the Support Services Professional is available 24 hours a day if an emergency arises. Home Based Services (HBS) is also provided so that the individual can remain in their own home.

In 2015, the National Council on Disability report concluded "individuals receiving home and community-based services and supports in smaller, more dispersed and individualized community settings demonstrated signs of greater community integration and positive life outcomes. The majority of studies conducted in the U.S. found that outcomes such as greater individual choice, satisfaction, housing stability, higher levels of adaptive behavior, and community participation are positively related to smaller and more integrated residential settings" (AUCD & AAIDD, 2015).

Shore receives the majority of referrals from Community Alternatives Unlimited (CAU) or Community Services Option, which are Independent Services Coordinators and referral agencies for the State of Illinois. We are part of the Home Based Support Coalition, which meets monthly as a network for developmental disability agencies in our region.

Additionally we work with area schools and other developmental disability agencies to promote our programs and services. Ninety percent of new referrals come from CAU.

We encourage our Supported Living Arrangements Program clients to apply for HBS funding. When a resident is selected from the Prioritization for Urgency of Need for Services (PUNS) list, which is a statewide database that records information about individuals who have developmental disabilities and are in need of services, they can use this funding to pay for support services.

**2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.**

Over 6 million individuals in the United States have developmental disabilities (Brault, 2010). More school-age children are receiving the diagnosis of a learning disability, developmental delay, or behavior disorder than ever before. In the Chicagoland area, there are over 2 million individuals with support needs that include the soaring diagnosis of autism.

Many of our residents who attend the Lois Lloyd Center have profound developmental disabilities and are fragile, both physically and medically. In addition, the vast majority (99%) have extreme financial challenges, the mean falling in the low-income and poverty levels. More importantly, participants in this program would most likely be turned away at other organizations, and have no other options for care and development. With the social services financial crisis, especially in Illinois, many organizations have closed their doors. Remaining providers have been forced to reject this population due to the fact the care of individuals with severe and profound developmental disabilities, physical disabilities and medical issues is both challenging and expensive. They simply don't have the financial resources to serve and support participant aspirations to reach their unique potential and enjoy the benefits of community inclusion.

For 70 years, Shore has been providing services to individuals with intellectual and other developmental disabilities and their families. This group has always been underrepresented. Since the majority of individuals in this group tend to not vote, they have a limited lobby both in Springfield and Washington D.C. Shore relies on limited reimbursement from the State to guide individuals to reach their greatest potential and live the lives they want. Through funding, more individuals will participate in various community experiences. As individuals are more visible in the community, the stigma of a developmental disability will slowly fade away. Individuals will be able to enhance relationships and receive support from people who are not paid to interact with them.

Individuals with developmental disabilities have historically been segregated in large residential facilities, or institutions, in "special" schools, in the workplace in sheltered workshops and in their residences (Disability Justice, 2021). Shore supports individuals with community access as we work to close our training center by March 2023 and expand our day programming services. States need to be in compliance with the Olmstead Act, which fully integrates individuals with disabilities into every aspect of community living.

Funding would help Shore maintain integrated living for individuals with disabilities in Evanston. Many would not be able to afford to live in the city if Shore did not subsidize their rent, as done at the Patricia Lloyd Townhomes, and provide supportive services that enhance their independent living skills. HBS services have also been expanded to children.

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

Shore does not turn eligible people away from our programs and services. In fact, we expanded our Home Based Services Program recently to include children ages 3-18 because there is a growing need for services for this age group. We are limited when it comes to residential placement because an individual served has life-long needs as it relates to their intellectual and other developmental disabilities and may live at Shore for the majority of their adult life. Currently, 18 individuals are on a wait list for placement in one of Shore's residential homes. There are openings for one person each at our Karger House and Brown CILA, Patricia Lloyd Townhomes, which serves individuals who are higher functioning and can live more independently, and at Shore Homes West in Skokie. Shore makes placements based on the appropriate functioning level of the individual for the home that has an opening. Many individuals attend one of Shore's day programs while waiting for residential openings.

**4. Does demand fluctuate throughout the year? If so, please explain.**

Demand tends to increase in the spring when students are finishing up their high school programming. Individuals seek adult programming and residential options.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

Case management is provided to individuals with intellectual and other developmental disabilities who live in Shore's homes, Community Integrated Living Arrangements (CILAs) and private homes in Evanston. Thirty-seven individuals (39% minority) were served last year and the demographics are as follows:

Age Range: 2% under 18; 89% 18-64, and 9% 65+

Gender: 61% Male and 39% Female

Race/Ethnicity: 61% White; 14% Asian, 12% Hispanic; 5% Pacific Islander, 4% Black; 2% Native American & 2% Bi-Racial

Family Status: 9% Have State Guardians; 64% Have a family member or friend as guardian and 27% are Self Guardians

Income: 100% Low

Disability: 100% have an intellectual and/or other developmental disability, which varies from 34% mild to 66%

moderate/profound and 75% require 24-hour supervision because of the severity of their disability.

Shore provides quality adult residential, Home Based Services (HBS) and Service Facilitation to children and adults with intellectual and other developmental disabilities. Primary residential eligibility includes: a diagnosis of an intellectual or other developmental disability; age 18; free of communicable, contagious or infectious disease; behavior adequate to avoid being of harm to self or others; sufficient medical stability to live in a group setting without frequent on-site medical care; recent application filed for social security benefits or receipt of such benefits; employment in a competitive or vocational work setting, approval of the regional Pre-Admission Screening (PAS) agency; preference of the parent/guardian/applicant/person served to enroll in the program; obtained appropriate government and/or other third party authorization for service; and completion of all required admission documentation.

Buehler House/Shore Homes East & West have 24 residents in a yearly 24-hour staff supported living arrangements that meets each individual's respective needs. Community integration is encouraged and programming is provided to improve independent living skills. All residents are in daytime employment, training or senior leisure programming.

The Supported Living Arrangements (SLA) provide services to individuals who are more independent. The Patricia Lloyd Townhomes and scattered-site apartments serve adults functioning in the mild range of intelligence.

HBS is provided to families and individuals with an intellectual or other developmental disability who have received an Illinois Department of Human Services award letter that states that they have access to funding for services, which includes: Service Facilitation, Personal Support Work, Developmental Training and Supported Employment, provided by the HBS Program.

Community Integrated Living Arrangements (CILAs) are homes for 1 to 7 residents, and meets the needs of each resident on a long-term basis. Staff-supervision is provided 24-hour a day on a yearly basis to individuals with more moderate to severe/profound disabilities.

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

103	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
40	Unduplicated Evanston residents to be served in 2021	
103	Unduplicated low/moderate income people to be served in 2021	
97	Unduplicated people served in 2020	
37	Unduplicated Evanston residents served in 2020	
97	Unduplicated low/moderate income people served in 2020	
37	Unduplicated low/moderate income Evanston residents served in 2020	
514.00	<b>TOTAL</b>	

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

Shore has provided services to 37 Evanston residents since January 1, 2021. We expect to enroll 6 new Evanston participants by December 31, 2021.

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

Alexandra Halilovic is the Director at Buehler House/Shore Homes East & West. She is a Caucasian female with a Bachelor of Science in Psychology; 6 years at Shore and is a QIDP. Ms. Halilovic acts as a case manager for 12 residents and is available 24-hours a day/7 days a week for crisis intervention. This position organizes an individual's services including: quarterly Interdisciplinary Team meetings; ongoing communication with the family, State Guardian or State assigned Case Coordinator; develops goals and objectives in accordance with the resident's needs; oversees staff in providing training to individuals and the daily data; completion of monthly summary reports and annual assessments; referral, linkage and follow-up with other organizations including Shore's day programs or an individual's employer.

Vicki Osborn is the Director of Home Based Support Services and has been at Shore for 2.5 years. She is an African American female with a Master of Arts Degree in Community Counseling, and is a Qualified Intellectual Disability Professional (QIDP) with over 25 years of experience in human services. Her responsibilities include: assisting families in identifying and

accessing the services of the HBS program; develops an Individual Service Plan (ISP) which describes the services, programming and objectives which will be worked on throughout the year; monitors services and programming regularly; links to other services and support; assists families to connect with a personal support worker, and additional case management services as needed. She also works closely with Direct Support Professionals (DSPs) to ensure that our residents in the Supported Living Arrangements program to receive the support needed and oversees the HBS Program.

Jacquelyn Stevens is the Support Services Professional (SSP) for the Supported Living Arrangements Program. She is a Caucasian female who has been employed by Shore for nearly 3 years and has over 15 years of experience. She provides supervision to 9 residents living semi-independently at the Patricia Lloyd Townhomes and 6 who live in scattered-site apartments in the community. The SSP monitors the physical and mental health of the SLA individuals and sees that they visit their doctor (e.g. Psychiatrist, Psychologist or Social Worker) at the recommended intervals. She monitors the individual's medication pillboxes and supervises that refills are obtained at the intervals prescribed by the doctors, but SLA residents self-administer their own medications. The Manager observes the health and behavior of each individual and implements programming for each Individual and Behavioral Plan. Other duties include: complying with reporting and documentation requirements; completing health and safety checklist, conducting fire and evacuation drills, holding council meeting, running an arts and crafts club, coordinating social/recreational activities, and more.

No new staff will be hired.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

Shore has 5 case managers in the residential and Home Based Services Program. The average caseload is 12 for the Homes; 17 for CILAs, and 22 for the two HBS staff.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

Shore uses the following methods when working with our individuals served:

Goal setting to improve skills for independence - monitored quarterly

ICAP Assessments (Inventory Client Agency Planning)

Individual Service Plans

Sexual Assessments

Behavioral Therapy and Management

Risk Assessments

Individual and Group Therapy

Resident Council Meetings

Monthly Trainings on different topics, weather safety, stranger danger, dental, appropriate behaviors, COVID-19, health and fitness, etc.

The organization is accredited by CARF International, formerly Commission on Accreditation of Rehabilitation Facilities, which is an independent, nonprofit accelerator of health and human services. CARF accredited providers are recognized for their ongoing innovation and adherence to the highest 'best practices' standards. Shore has received the highest accolade: 16 consecutive 3-year accreditations.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

Shore is dedicated to providing ongoing trainings for staff that focuses on best practices and how to implement programs that are truly person-centered. We make sure that all employees receive the recommended training to maintain their professional certifications over and above what is required by our certifying/licensing and funding bodies. For example, a Qualified Intellectual Disabilities Professional (QIDP) needs to complete 12 hours of Continuing Education Units (CEUs) yearly to maintain this distinction. Registered Nurses are required to complete 20 hours every two years for their professional license. Direct Service Professionals (DSPs) also complete various trainings throughout the year to maintain and upgrade their skills.

We value and leverage collaborative relationships. In 2017, Shore joined two collaborative organizations for training. Infinitec, which is a collaboration of 20 disabilities organizations in the greater Chicagoland area, and Human Services Management System (HSMS) - a collaboration between 15 disabilities organizations to develop software program for case management; ongoing training for the program; and offers best practices in case management documentation. Additionally, stakeholders e.g. our staff, individuals served, families and Personal Support Workers for the Home Based Services Program are given access to Infinitec, which has over 1,000 videos that offers trainings and certificate opportunities to become more knowledgeable about serving individuals with developmental disabilities. Topics include: health, food preparation, aging, behavior management and more.

Annual staff surveys are conducted to seek input from staff on the types of training that they want and need. We have four in-

services throughout the year that are used for staff trainings. As part of a Strategic Planning for the agency's future, all staff were asked for feedback on ways to improve Shore through programming, marketing, technology upgrades and other pertinent issues through SWOT (Strengths, Weaknesses, Opportunities and Threats) that were conducted by a consultant. Directors work closely with their staff and have meetings, some daily, to discuss programming and other issues. DISC trainings were offered to leadership and program managers to learn how to better communicate with others, which helped in engaging all staff in decision making. In addition, Dr. Dianne Dawson is a consultant who has been working closely with our leadership and manager level staff on improving communication.

Finally, when resources are available, tuition/training for staff as it relates to the professional growth in their area of expertise is reimbursed. For example, our Chief Financial Officer is now a Certified Payroll Professional (CPP) and the Senior Philanthropy Officer is a Certified Fund Raising Executive (CFRE). It was through the encouragement and high standards for excellence held by Shore's CEO that these certifications were obtained

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

Case Management includes review of client goal tracking quarterly and updating as needed to achieve independence. At the Buehler House/Shore Homes East and the Brown CILA, we speak with our residents daily to help them achieve their wants, needs, and improvements in the areas in their life they want to address. Clients are given options as to when it is convenient for them to meet with staff. Their engagement is measured by the goals they are working on and what we can do to help them with developing and achieving their goals. The Case Managers, who are Qualified Intellectual Disabilities Professional (QIDP), visit the homes and CILAs weekly and meets monthly with staff to discuss client progress. Daily activity calendars are also reviewed to make certain community integration goals are being met.

Intake meetings are held quarterly, but potential new clients are reviewed more regularly especially when openings are available in our homes and in the HBS Program. Residents do not come and go from the facility unless they need more skilled nursing care. They remain at Shore for the majority of their adult lives.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

For Shore residents, service plans are completed annually. The plans are comprised of a team with information on the individual's medical, psychological, physical, and independent learning skills. Since the plan is person-centered, individuals are strongly encouraged to provide feedback and be a part of the discovery plan, if they are able. All plans have a focus on community activities and integration. Individuals are given opportunities and support to develop and maintain natural supports to develop relationships with others who are not staff who are paid to work with them. In addition, skill development and growth in areas of self-advocacy, economic self-sufficiency, socialization, use of community resources, daily living and independent living skills and self-administering medications are addressed.

Most clients are not able to provide documents themselves, so guardians are present at the staffing. Case management is coordinated by Qualified Intellectual Disability Professionals (QIDPs).

If support from a contractual Board Certified Behavior Analyst (BCBA) is needed, a separate behavior plan will be included in an individual's service plan. Services include: behavioral assessment, development of a behavior support plan and ongoing evaluation and supports.

Community Alternatives Unlimited (CAU), the state authorized referral agency, is responsible for developing service plans for individuals who receive Home Based Services. Shore will implement and document progress on the goals in the plan accordingly.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

A service plan with a Shore resident is based on their individual interests, skill levels, goals and desires. There are common goals implemented per state rules and regulations, which includes: Money, Activities of Daily Living, Hygiene, Community Integration, Medication, self-direction and other skills needing to increase independence. Typical outcomes on an annual goal are usually not achieved primarily due to the nature of the individual's developmental level. Sometimes the goal may run for two years in order to potentially achieve it. If the goal is not achieved it is usually dropped per regulations.

For Home Based Support clients, Community Alternatives Unlimited (CAU) creates the service plan and Shore is responsible for the implementation.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

Service plans are reviewed annually based on daily and monthly case notes. On a monthly basis, the plan is updated by the Program Manager and adjustments or addenda are implemented at any time if there are changes in the individual's life. Case notes are conducted every time our staff have interactions with the individual served and/or their family.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

The pattern of engagement varies with each individual but average meetings are hourly with our residents. The Case Manager is also on call at all times to engage in any type of situation that may arise with our residents.

For the residents who live with their families and receive Home Based Services, they receive a monthly allotment of \$2,349 for adults and \$1,566 for children as of January 2020. These funds are used at the discretion of the individual and/or family to help maintain residency in their own family home.

Self-Direction Assistance (SDA) is an optional waiver service for purchase that is available in both the Children's and Adult Home-Based Waivers. A Self-Direction Assistant can help with arranging for, directing and managing of an individual's Personal Support Worker (PSW). An SDA can also provide skills training designed to better recruit and hire PSWs and provide information on effective communication and problem-solving skills. When Shore is hired as a SDA, we spend at least 3 hours a month with each HBS family up to 8 for new enrollees. The individual and/or family is given a referral packet, service agreements, authorizations and consents from Shore if they are selected to be managed by our HBS staff. Shore reviews monthly billing and reports from the PSW and submits the information on-line in ACCESS Financial Management Services in order for funding to be approved.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

The process of maintaining documentation is through Case Notes and communication logs with staff. The Qualified Intellectual Disabilities Professional (QIDP) reviews these documents regularly. Each client has their own binder where case notes and pertinent documents are stored securely.

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

A client never graduates from case management unless they move out of a Shore residential site. We provide daily 24-hour staff supervision at Buehler House/Shore Homes East and our Brown CILA. The majority of our residents are never allowed per regulations to be on their own without staff supervision due to the moderate to severe level of their disability. The ultimate goal for each individual is to live a more fulfilling life that focuses on self-governance. The most realistic goal is to be semi-independent in the least restrictive setting. Shore looks at graduation as progression with personal goals and an individual obtaining independence at the level that is most appropriate for them.

Shore addresses the health, nutrition and fitness needs of our residents who have varying levels of an intellectual or other developmental disability and reside in our homes. Often service plans have a health goal to combat the profound effects of aging. Due to the limited resources and cognitive skills, the majority of residents have difficulty taking the necessary steps towards a healthier lifestyle. Several studies refer to the need to adjust the concept of aging for developmentally disabled adults, and refer to "premature aging and an earlier decline in functional skills" for this population (Practical Geriatrics, March 1999).

In recent years, there has been an increase in a variety of health-related conditions that have affected many of Shore's residents including: high cholesterol, obesity, hypertension, arthritis and Crohn's Disease. Many of these conditions can be related to a lack of awareness and the ability to incorporate elements of a healthy lifestyle into their daily schedule. Unfortunately, poor health can threaten our residents ability to maintain their level of self-sufficiency and independence and overall the integration within the community. Residents are encouraged to read food labels, use their portion plates so they do not overeat and exercise on a regular basis, which includes: walking, working out at home on an exercise bike or treadmill or participating in fitness classes. They also have regular discussions on health topics and ways to prevent falls from occurring, which has been an issue with some of the older residents. In turn, the community also benefits by helping to keep individuals with developmental disabilities in their community, which is the least restrictive environment and less costly than institutional care.

For adults who are higher functioning, the graduation comes when they no longer need support from staff. We follow up once a year for several years when a client is discharged.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the barriers to receiving those services?**

Home Based Services (HBS) are provided to families and individuals with an intellectual or other developmental disability who have received an Illinois Department of Human Services (IDHS) award letter that states that they have access to funding for services, which includes: Service Facilitation, Personal Support Work, Developmental Training and Supported Employment, provided by the HBS Program. HBS is a self-directed program to help individuals continue living safely and successfully in their own home or with family, with the goal of promoting maximum growth and independence. Individuals and families manage their own services and supports to meet the needs and outcomes of the individual's personal plan. A monthly allocation from the State of Illinois can be used to purchase services from community agencies like Shore (e.g. day programming, budgeting, service facilitation, counseling, behavioral health) or to pay for Personal Support Workers (PSW) who support the individual or their family. For our residents in the Supported Living Arrangements (SLA) Program, they use their HBS funding for extra support services like budgeting and grocery shopping to help them maintain independence especially as they age and encounter more health issues. In fact, the majority of the individuals who receive HBS would not be able to maintain residency in a less restrictive environment without this support.

As a state waiver program, Shore assists the individual or family with all required paperwork for billing; schedules a Personal Support Worker for our residents and provides support for obtaining other eligible benefits (e.g. Link, assistive technology, adaptive home improvements and more. With the added support, individuals are able to be as independent as possible while integrated into their community.

Other services include: having benefits re-instated( e.g. SSI/SSDI); seeking PACE or taxi passes for transportation needs; scheduling medical appointments; and seeking community employment with assistance from our Supported Employment Program (SEP). The subsidy Shore provides the residents at the Patricia Lloyd Townhomes, which varies from \$314-\$595 per resident (based on income) is a key opportunity for our low income residents to afford living in Evanston. The rent ranges from \$296-\$697 per month. These residents require additional support, which for several comes from HBS funding, in order to maintain this level of independent living.

The barriers to receiving services include: waiting for openings at our residential sites and being selected from the PUNS list for HBS in order for payment for day programming or other support services.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

Shore operates three programming divisions, two community day programs and a variety of residential options. The agency strives to find the most appropriate program for each individual. Shore's Social Worker handles all inquiries and intake for the residential placement. She documents an individual's interest for residential placement and sends them a complete Intake Packet as attached. Periodic contact with individuals on the waiting list is made and information/referrals are offered as needed. Residents interested in living at the Buehler House/Shore Homes East, which is an Intermediate Care Facility, usually have an easier time with placements because they have Medicaid funding.

If it is determined that Shore is unable to provide the best possible programming to an individual, that individual will be referred to Community Alternatives Unlimited (CAU), which is the local PAS agency who will help them find the most appropriate program to help serve their needs.

Other partnerships and referrals include: Northwestern University Best Buddies Program has helped residents who need companionship. Residents attend the YadR'Yad program facilitated by Jewish Family and Children's Services that provides integrated socialization opportunities for Jewish adults with and without disabilities. Many residents participate in Evanston Special Olympics; Levy Center, Keshet, YWCA's New Year Co-Ed's, Center for Enriched Living and Maine-Niles Association Special Recreation (MNASR) for exercise and community integration activities. The Levy Center also provides free tax preparation for many of our residents. Some residents are members of Evanston houses of worship, and others have attended Shabbat activities at the Beth Hillel Congregation in Wilmette, which offers a community integration experience for people without disabilities to be introduced to individuals with disabilities. Our residents have enjoyed the social interaction and have forged friendships with members of this congregation. Additional counseling is available to residents of the Supported Living Arrangements Program through a private Social Worker. Patricia Lloyd Townhomes residents receive healthy food delivered through St. Francis' Meals at Home Program.

We strongly encourage our residents to be integrated in their communities and to develop natural supports that enrich their lives.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

Yes, Shore has service arrangements with other developmental disability agencies primarily to provide day program services for their residents either at our Lois Lloyd Center or the Joseph Koenig, Sr. Training Center. Individuals or families who want service from our Behavioral Analysts sign a consent agreement, which allows us to bill directly for this service. We have service agreements with all independent contractors (e.g. nurses and Psychiatrist) along with our pharmacy company TarryTown and Roche Dieticians for dietary plans). In terms of leisure activities, Shore will obtain agreements with Center for

Enriched Living, New Year Co-Eds and Music Institute for Therapy Through the Arts, which indicates the cost for the service provided.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

For over 70 years, Shore's mission is to improve the quality of life for individuals with intellectual and other developmental disabilities. Our goal is to help children and adults reach their full potential so they can lead more independent and productive lives. This is accomplished through educational, residential, vocational and related programs, along with community integrated support services.

In 1951, the late Lois and Thomas Lloyd, along with a group of Evanston parents, co-founded Shore Community Services. The Lloyds had a daughter named Patricia, fondly called Patty. In the late 1940s, the Lloyds were unable to find proper services for Patty because nothing was available for children with developmental disabilities. As a school teacher, Mrs. Lloyd believed that Patty, and other children with special needs, deserved the very best education possible. By collaborating with other families in Evanston and neighboring communities, a school program was started in the basement of the Lloyd's home. Rapid growth necessitated the need for larger accommodations. This was accomplished by aligning the organization with local churches and area businesses.

In 1953, Shore was selected to be 1 of 6 schools to participate in a statewide research project to determine if children with developmental disabilities could benefit from public education. The school's success led to its incorporation in 1954, when it became part of Evanston-Skokie School District 65. As the progressive idea of inclusion moved to the forefront, and institutionalized care diminished, Shore continued to grow and develop more diversified programs. Today, we provide a comprehensive array of services that benefit over 300 individuals each year, including: small group homes, CILAs (Community Integrated Living Arrangements), Supported Living Arrangements, Vocational Training & Employment Services, Adult & Seniors Program, Life in Motion Your Choice Program, True North, Early Intervention and Home Based Support Services.

The organizational structure consists of the Board of Directors that oversees the CEO India Alexis Ehioba, MNA, CFRE. The CEO is responsible for running the agency and the Program Directors supervise their respective staff. The Board is encouraged to support the following three areas: Development: fundraising events, marketing, recruiting attendees, sponsorships and acting as representatives for the agency; Policy: approves annual budget, capital expenditures, approves operational policies and employs CEO who in turn employs Program Directors and other staff; and Accountability: attends board and committee meetings, monitors monthly financials and efforts to improve quality and quantity of programs, and performs all functions in an objective manner without personal interest affecting the agency. There are 19 Board and 9 Honorary Board Members.

Due to COVID-19 mandated shutdowns, day programming was provided in the homes for most residents until September.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

We have a long history of successfully implementing programs and capital improvements funded by the Evanston Mental Health Board and Community Development Block Grants. Policies for finances and procurement are detailed and funding is put into QuickBooks.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

Shore gets feedback from our individuals served, families and staff who work directly with our clients. Person-Centered Individual Program plans are developed by an Interdisciplinary Team annually, with measurable goals that focus on areas of self-care, self-direction, mobility, money management and capacity for independent living. A yearly staffing is held to review progress and to set new goals, if desired. Behavior programs are developed for those individuals who need self-direction support, which comes from an individual, family or staff member directly. Shore has two part-time certified Behavioral Analysts who help our clients reduce maladaptive behaviors and increase their skill development to promote more independence. The Human Rights and Behavior Management Committee reviews behavior plans quarterly.

Yearly, individuals and their parent/s or guardian/s are also surveyed on their overall satisfaction with the program. This feedback is used to help enhance program offerings.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is**

**engaging people of color in decisions?**

Residential Services, which includes our Evanston homes and CILA and HBS Program, has 40 employees. The education levels include: 19 High School Degree; 8 Bachelor Degree; 5 Master Degree; 3 with some college; 2 Registered Nurses, 2 Certified Nursing Assistants. The Senior Program Officer has a Master Degree in Public Health, and is a Qualified Intellectual Disability Professional (QIDP) and has been at Shore for nearly 3 years. She is an Asian female. The Director at Buehler House/Shore Homes East & West has been at Shore over 6 years and is a QIDP. She is a Caucasian female with a Bachelor of Science in Psychology. The Director of Home Based Services (HBS) has been at Shore for 2.5 years, is a QIDP; and is an African American female. The Support Services Professional has been at Shore since May 2018. She has over 15 years of experience and is a Caucasian female.

Out of 78 employees at Shore, we have 12 African American, 2 Asian and 1 Hispanic in leadership/decision-making positions, which is 19%. Shore's Chief Executive Officer is African American. The agency always tries to hire qualified staff for all open positions regardless of race/ethnicity. Our staff have a rich cultural background, with 13 languages spoken in addition to English, which improves communication with our clients and their families. In addition, feedback is sought from all staff on various topics to engage them in decisions that have the best impact for our agencies and individuals served. The Board also works to promote open positions as a way to attract individuals with desired experience to apply at Shore.

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

06-861-8826

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

- Yes
- No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

*IF "YES," ENTER "NA."*

Buehler House/Shore Homes East & West and some scattered-site locations are ADA compliant but the Townhomes and Brown CILA are not. Our Administration Center in Skokie is used for meetings if accessibility is an issue for a family member or guardian.

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

Buehler House/Shore Homes East-503 Michigan Ave., Patricia Lloyd Townhomes-1823-31 Brummel, and Brown CILA -727 Brown. Additional clients receive services in private homes in Evanston and beyond. Clients self-transport or are dropped off for services.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

India Alexis Ehioba, MNA, CFRE, CEO

## Budget [top](#)

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Mental Health Board Funds	USD\$ 19,602.00	USD\$ 30,000.00	USD\$ 0.00
Fees for Service & Grants Public	USD\$ 624,568.00	USD\$ 855,966.00	USD\$ 855,966.00
Grants - Foundations, Corporations & Businesses	USD\$ 6,180.00	USD\$ 20,700.00	USD\$ 20,700.00
Client/Family & HUD Rent Payments	USD\$ 207,591.00	USD\$ 183,675.00	USD\$ 183,675.00
Contributions	USD\$ 1,325.00	USD\$ 2,070.00	USD\$ 2,070.00
Special Events/Fundraising	USD\$ 22,330.00	USD\$ 38,502.00	USD\$ 38,502.00
Other Income	USD\$ 4.00	USD\$ 98.00	USD\$ 98.00
<b>Total</b>	<b>USD\$ 881,600.00</b>	<b>USD\$ 1,131,011.00</b>	<b>USD\$ 1,101,011.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
City of Evanston Mental Health Board Funds	USD\$ 19,602.00	USD\$ 30,000.00	USD\$ 22,500.00
Salaries	USD\$ 610,514.00	USD\$ 621,008.00	
Program/Administrative Salaries	USD\$ 22,730.00	USD\$ 24,217.00	

Health Insurance, Worker's Comp & Other Benefits	USD\$ 106,661.00	USD\$ 108,300.00	USD\$ 5,200.00
Payroll Taxes	USD\$ 45,769.00	USD\$ 46,684.00	USD\$ 2,300.00
Professional Fees & Contracts	USD\$ 32,162.00	USD\$ 27,524.00	
General Operating	USD\$ 109,057.00	USD\$ 129,888.00	
Occupancy	USD\$ 26,366.00	USD\$ 73,385.00	
Misc./Depreciation	USD\$ 22,957.00	USD\$ 34,155.00	
<b>Total</b>	<b>USD\$ 995,818.00</b>	<b>USD\$ 1,095,161.00</b>	<b>USD\$ 30,000.00</b>

## Budget Narrative

Shore's Fiscal Year runs July 1st-June 30th. The budget for 2021 is significantly higher than 2020 because it includes our Brown CILA, the Patricia Lloyd Townhomes - Supported Living Arrangements, Buehler House/Shore Homes East, and Home Based Services. Two residential openings are available at the Brown CILA, which is a single family home, and at the Patricia Lloyd Townhomes, both in Evanston. Since there is a great demand for affordable housing, we feel the additional residents would benefit from community living while helping to turn the operating budget for the CILA to a surplus, which annually ran over a \$40,000 deficit. Also, our residential programs received a temporary increase to provide day programming in the homes during the pandemic.

The agency focuses on ways to increase performance and energy efficiency to reduce costs. Grants to upgrade lighting and HVAC units, which decrease energy costs, have been received. Shore explores other revenue resources to diversify income sources to cover operating and capital needs as rising costs occur in transporting individuals to/from home; repairing aging vehicles, general maintenance; and worker's compensation insurance. Shore's Joseph Koenig, Sr. Training Center created a new electronic recycling business called Shore eCycle and is a partner with Cyclepoint from SourceAmerica's electronic recycling program. This business has the potential to be a new revenue stream for the agency while providing valuable employment opportunities and an environment friendly initiative.

Shore currently must raise 15-20% of its total annual budget from philanthropic contributions. A part-time Director of Annual Giving was hired to help the one-person Development Department with fundraising efforts. She is responsible for special events, marketing, grant writing and will assist with all areas of fundraising.

The positions with salary, benefits and taxes, that MHB funding is being sought are the Director of Shore Homes (Buehler House/Shore Homes East & West) - \$56,000, Director of Home Based Support Services - \$52,000 and Support Services Professional for the Supported Living Arrangements Program (SLA) - \$35,000; which represents 5% of their salaries. All three positions are currently filled, and Evanston residents are the only ones served by two of the staff. Shore is seeking an increase because additional service hours are being provided to our individuals served especially as they age and require more medical attention. Also, two new residents will be added and our Home Based Services Program is expanding since we now provide services to children. The services Shore provides will enable our clients to build their confidence in order to live a more self-sufficient lifestyle.

## Program Outcomes [top](#)

### Program Outcomes

	Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
1	100% (37/37) Evanston residents will maintain their residential placement, preventing placement in a more restrictive setting.	Based attendance records by 12/31/21.	37	37	74			0
2	84% (31/37) Evanston residents will improve their independent living and community integration skills.	Based on staff attendance records and Activity Log by 12/31/21.	31	31	62			0
3	86% (20/23) Evanston residents will live healthy by maintaining their ideal body weight.	Measured by tracking logs and case notes by 12/31/21.	20	21	41			0

4				0		0
5				0		0
<b>Total</b>		<b>88</b>	<b>89</b>	<b>177</b>	<b>0</b>	<b>0</b>

### Program Line Item Expenditures

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1 City of Evanston Mental Health Board Funds	30,000				\$ 0
2 Salaries	621,008	22,500			\$ 0
3 Program/Administrative Salaries	24,217				\$ 0
4 Health Insurance, Worker's Comp & Other Benefits	108,300	5,200			\$ 0
5 Payroll Taxes	46,684	2,300			\$ 0
6 Professional Fees & Contracts	27,524				\$ 0
7 General Operating	129,888				\$ 0
8 Occupancy	73,385				\$ 0
9 Misc./Depreciation	34,155				\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>1,095,161</b>	<b>30,000</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1 City of Evanston Mental Health Board Funds	30,000	30,000			\$ 0
2 Fees for Service & Grants Public	855,966				\$ 0
3 Grants - Foundations, Corporations & Businesses	20,700				\$ 0
4 Client/Family & HUD Rent Payments	183,675				\$ 0
5 Contributions	2,070				\$ 0
6 Special Events/Fundraising	38,502				\$ 0
7 Other Income	98				\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>1,131,011</b>	<b>30,000</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

Documents [top](#)

Documents Requested \*

Required? Attached Documents \*

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.



[Audited Financial Statements FY 19 & 20 Form 990](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

[Fiscal Year 2020 Annual Report](#)

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).



[Exemption Status](#)

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

[Non-Discrimination Policy](#)

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.



[Staff Resumes & Demographics](#)

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

[Accessibility Plan](#)

Supplemental information relating to your program or agency, as applicable.

[Strategic Plan](#)

[Marketing Plan](#)

[Strategic Plan FY18-21](#)

[Short & Long Range Plans for CILAs](#)

[Short and Long Range Plans for Supported Living Arrangements Program](#)

[Short & Long Range Plans for Home Based Support](#)

[Winter Newsletter 2020](#)

[Short & Long Range Plans - Residential](#)

Form used to document income of participants to establish eligibility.

[Financial Aid Form, Rent Chart for SLA Program & Award Letters](#)

[Income information for Shore Homes](#)

HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Policies/procedures for case management process and case file documentation/maintenance.

[Record Location and Retention Schedule](#)

[Shore Homes Evaluation & Service Plan Procedures](#)

[Home Based Support Intake Procedures & Forms](#)

[Case Note Form for Shore Homes & CILAs](#)

[Case Note form for HBS Program](#)

[ACCESS Information for Employers of HBS](#)

[ACCESS Information for PSW Workers](#)

[Intake Packet for Shore Homes](#)

[Social History Questionnaire for Shore Homes Intake](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.



[Chart of Accounts](#)

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).



[Statement of revenue and expenses](#)

Organizational commitment to equity, diversity and inclusion.

[Diversity](#)

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[Fiscal Year 2021 Operating Budget](#)  
[Program Budgets](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

[Board of Directors](#)

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form.



[Conflict of Interest Disclosure Form](#)

[download template](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.



[Duplication of Benefits Disclosure Form](#)

[download template](#)

\* ZoomGrants™ is not responsible for the content of uploaded documents.

Application ID: 350142

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

Trilogy Inc  
**Trilogy Behavioral Healthcare - Evanston Mental Health Program**

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 30,000.00** Requested

Submitted: 4/21/2021 1:11:52 PM (Pacific)

**Project Contact**

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**President and CEO**

Samantha Handley  
[shandley@trilogyinc.org](mailto:shandley@trilogyinc.org)

**Application Questions** [top](#)

**1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?**

Trilogy clients get enrolled in our case management services in a variety of ways. In response to COVID19, Trilogy began conducting virtual intakes and assessments. This allowed us to link clients to case management services without requiring them to leave their homes, use public transportation, come into our office etc. and risk exposure to COVID19. Although we ceased in person intakes for several months, in November 2020 we resumed our walk-in hours for intakes and assessments at our 1400 W Greenleaf location on Mondays and Thursdays. The walk-in hours allow those without a phone to access services as well as those that do not have a home or space to engage in a phone intake and assessment a place to do so. Many individuals are self referrals who heard about us from another client, a different service provider, a family member, a friend, or who have come across us via internet search. Several clients are referred directly to us by a variety of entities including hospitals, school social workers and teachers, police departments, other social service agencies unable to accept new referrals, current medical providers such as primary care doctors, psychiatrist, or therapists. Approximately 60% of clients are self referrals. Our main referrals for Evanston residents at this time are from St. Francis Hospital, Connections For the Homeless, and our walk-in hours for intake. We receive funding from Evanston Community Foundation that allows our Intake Specialist, Kelly Jones, to conduct virtual intake hours at least twice a month specifically for individuals receiving services from Connections For the Homeless. These funds have enabled us to reach those that likely would not have access to a phone to contact our intake line or means to transport themselves to our walk-in hours. We also receive funding from St Francis Hospital that allows us to have Community Linkage Liaisons embedded in the hospital 40 hrs a week conducting linking individual to case management services at Trilogy or referring to services elsewhere should someone be ineligible or need services outside the scope of Trilogy.

**2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.**

Our staff engage clients referred for services by the aforementioned referral sources. Many of our Evanston referrals come via out walk-in hours, Connections For the Homeless, and through St Francis Hospital. In engagement process staff are educating client about services, Trilogy providers, and conducting a thorough assessment of client's needs in several areas including but not limited to mental health, physical health, emotional, financial, housing, and employment needs. In attempt to generate more referrals, staff provide education to other treatment providers and community members about the services we provide in order to generate referrals for individuals who would not otherwise refer themselves. At times we may contact

someone directly who has been referred to us or outreach them at their home or on the street if they are homeless to engage in services.

Without city funds we will still conduct intakes for Evanston residents seeking mental health services as we always have, as well as the provision of these services to eligible clients. There would, however, be significantly less outreach within the Evanston community to identify individuals who would benefit from receiving a mental health assessment and services and support from Trilogy. At this time we are at Connections For the Homeless bimonthly and City funds would allow us to be there more frequently, and as a result, link more Evanston residents to needed case management services. In addition, City funds would allow us to work with individuals who do not have insurance. Trilogy primarily provide case management services to those with Medicaid insurance, however in the past we have utilized EMHB grant funds to allow us to serve unfunded Evanston residents and support them in obtaining medical insurance as part of the case management services. Obtaining medical insurance gives resident significant more access to needed resources. We would also seek to utilize City funds to increase our outreach services to physically go into the community to engage people in their homes, at a shelter, or in the street. Lastly, City funds would increase opportunities to receive referral through Evanston schools which would allow us to link both youth and their parents to needed case management supports.

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

There is no wait list. We offer immediate linkage services for eligible individuals following the assessment period to begin the process of helping individual's access care such as psychiatry, primary care, case management, therapy services, among other supports. Clients can then access more long-term, intensive supports as needed. Our intensive case management services, our Community Support Team (CST) and Assertive Community Treatment (ACT), are rarely able to accept clients immediately. In order to prevent turning people away who are eligible for services Trilogy has a Linkage Team. The Linkage Team providers interim case management services until they can facilitate a transfer to a CST or ACT team. The Linkage Team focuses on meeting immediate needs including but not limited to identifying housing options, linkage primary care, linkage to psychiatry, support with obtaining medications, and applying for entitlements such as LINK, SSI, and SSDI.

**4. Does demand fluctuate throughout the year? If so, please explain.**

The number of individuals seeking our services is relatively consistent throughout the year. Typically in the winter months we see a slight increase in specifically seeking housing supports.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

The direct beneficiaries of Trilogy's Evanston Mental Health Program are Evanston adults who are living with mental illness. This includes homeless adults, many of whom have never been assessed for mental health issues and have never received mental health services; people with untreated substance abuse issues who don't know what treatment options exist; people living in one of Evanston's nursing homes that house people with mental illness; and other adults with undiagnosed and untreated mental illness.

In FY 2020 Trilogy provided services to 90 Evanston residents. We saw a decrease from FY19 due to COVID19. All 90 residents fell in the very low income reporting category - Less than 30% of median and over 20% were homeless at time on engagement. All little less than half (46%) of Evanston client were African-American, while 40% were Caucasian, 11% were Hispanic, 1% were Asian, and 2% fell in the other category. There were more male clients (62%) than female. By age, majority of residents were between 18 and 64 (84%), 13% of clients were 17 and under, 3% were 65 or older.

To be eligible for services and become a Trilogy client, there must be a diagnosis of a mental illness. The primary mental health diagnosis for Evanston clients in FY 2020 were bipolar disorder, schizoaffective disorder, schizophrenia, major depression, and other (ADHA, mood disorder, PTSD, or anxiety).

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

375	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
115	Unduplicated Evanston residents to be served in 2021	
375	Unduplicated low/moderate income people to be served in 2021	
325	Unduplicated people served in 2020	
90	Unduplicated Evanston residents served in 2020	
325	Unduplicated low/moderate income people served in 2020	
90	Unduplicated low/moderate income Evanston residents served in 2020	

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

As of January 1, 2021 38 Evanston residential were enrolled in case management services. By December 31, 2021 expect to have a total of 75 residents enrolled.

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

Staff 1: Caucasian Male. 3 years. MHP  
 Staff 2: Hispanic Female. 3 years. MHP  
 Staff 3: Caucasian Female: 7 months. MHP  
 Staff 4: Hispanic Female. 3 years. QMHP  
 Staff 5: African American Male. 5 months. PHD.  
 Staff 6: Caucasian Female: 7 years. LCSW.  
 Staff 7: Caucasian Female. 5 years. LCSW  
 Staff 8: Caucasian Female: 2 months. QMHP  
 Staff 9: Caucasian Female: 8 years. LCSW  
 Staff 10: Caucasian Female. 8 years. LCSW  
 Staff 11: Caucasian Female 6 years. LCSW

The intake team does not carry a caseload. Their responsibility is to open and link clients to services within the agency. They do not work with client's long term. Each intake staff opens between 0-10 client's to services a week via Open Access or scheduled intake referrals. The linkage team provides intake and linkage (brief case management services) and carry a caseload of 20 clients.

No new or additional staff will be hired for this program. The position will not be retained as it currently exists without City funding, unless another public or private funding source replaces it. Intake Specialist Kelly Jones will complete intakes, assessments, and facilitate linkage to case management services. Ms. Jones has been an Intake Specialist with Trilogy since March 2019. During that time she has worked with hundreds of clients seeking services, providing intake and assessment services and getting them linked with appropriate programs. This has included collaboration with community partners including various long-term care facilities, homeless service providers and other agencies. Prior to joining Trilogy, Kelly spent 13 years in clinical operations for another Chicago non-profit that provides behavioral health services to the homeless community; duties there ranged from overseeing the integration of behavioral health services into a primary care setting to providing clinical supervision of new staff and program oversight. Kelly earned her masters degree in social work in 2005 from Loyola University Chicago, which included an internship at Hilda's Place with Connections for the Homeless. Kelly is also an Evanston resident currently.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

A case manager's caseload varies depending on the client's level of care. At our highest level, a case manager has a total of 8 clients due to severity of need. At our lowest level, a case manager has approximately 20 clients on their caseload.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

At Trilogy, we utilize a wide-variety of evidence-based practices in our outpatient clinics, school-based sites, case management teams, and in our integrated health clinic. Trilogy operates from an integrated health approach. It is through primary care and behavioral health integration that our teams are able to provide increased access and coordination to needed services that help to increase health and behavioral health outcomes. Our clinical teams are trained in evidenced-based practices and have specific specialties. All mental health services are provided through a trauma-informed, strengths-based, and culturally and gender-responsive lens. Such strategies include: Motivational Interviewing, Trauma Focused Cognitive Behavioral Therapy, Cognitive Behavioral Therapy, Depression Treatment Quality Index, Dialectical Behavioral Therapy, Seeking Safety, Eye Movement Desensitization Reprocessing, Harm Reduction, Sand Tray Therapy (Child and Adolescent), and Assertive Community Treatment.

The overarching goals of Trilogy's programming include a decrease in negative outcomes associated with childhood and adult trauma and mental illness, including homelessness or housing instability, incarceration, high risk health behaviors, and perpetuation of intergenerational trauma. Our programs and partnerships work towards a vision that focuses on ease of access to services/resources and utilizing individual resilience to actualize their goals and engage constructively in their communities.

Mental health screenings, yearly screening of all patients for depression (PHQ-9), Screening, Brief Intervention and Referral to Treatment (SBIRT), comprehensive biopsychosocial assessment, collaborative treatment planning, individual and group psychotherapy, and advocacy are other evidence-based practices that support people in their recovery. As we expand our services in the Evanston community, we anticipate serving populations that will continue to utilize these evidence-based practices, in addition to the use of telehealth to deliver behavioral health services. The use of telehealth is a key component to

expanding and creating access to needed services, not only during a pandemic, but ongoing as technology has changed to allow for easier access to care.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

Each year Trilogy conducts 2-3 mandatory trainings for clinicians focused on following our code of conduct and review our values. In addition over the course of a year Trilogy offers staff between 15-20 voluntary trainings on a variety of topics to further develop clinical skills and provide most up to date evidence based practices. These trainings are a mix of internal and external providers. Lastly, staff are able to independently identify trainings they would like to attend and whenever possible, Trilogy covers the cost of attendance.

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

Trilogy's case management services are offered at multiple levels of care based on the client's need. At our lowest level of care clients are seen weekly to biweekly by their case manager. At our highest level of care clients are seen up to 7 days a week by a case manager. Case management services include but are not limited to support with locating housing options, help with completing independent activities of daily living such as grocery shopping and cleaning, support with obtaining medications from a pharmacy, taking them as prescribed, and learning names and reasons for taking medication. Case managers also accompany clients to doctor appointments, included transportation to and from, assist with applying for entitlements such as LINK and SSI/SSDI and also assist with referral and linkage to primary care providers, psychiatrist, individual therapist, group therapy, supported employment specialist, occupational therapist, and housing coordinator both within Trilogy and in the community when appropriate. Appointments can last anywhere from 30 min to several hours. Client engagement is measured based on number of contacts with their case manager which are documents in case notes in our electronic medical records. Engagements include in person appointments, phone calls, and video calls. All services at Trilogy are voluntary. Should a client disengage in services staff assess reason for disengagement and attempt to address any barriers to doing so. Should a client refuse services their case is closed and they are eligible to return to reengage in the future should they choose to. There are times clients choose not to engage and are closed, but change their minds and return requesting to be reopened to services. In these cases we welcome clients back and reopen their case.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

Trilogy clients are not required to provide any documentation whatsoever at intake or during the development of their service plan, which we refer to as a treatment plan. At intake Trilogy conducts the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) with the client. The IM+CANS is a comprehensive, lifespan tool for assessing the needs and strengths of individuals who require mental health treatment in Illinois. The IM+CANS integrates assessment and treatment planning into a single process. It contains a complete set of core items that assess function across multiple life domains such as risk behaviors, trauma exposure, behavioral/emotional needs, substance use, and cultural factors, as well as a physical health risk assessment. Each client is given a rating in each domain. A higher rating indicates a recommendation for goals in the client's treatment plan. Clients dictate and identify which goals become a part of their treatment plan based on what they would like to work on with their case manager.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

A client's initial treatment plan is developed during their intake process. As stated above, in the IM+CANS assessment, each client is given a rating in each domain. A higher rating indicates a recommendation for goals in the client's treatment plan. Clients dictate and identify which goals become a part of their treatment plan based on what they would like to work on with their case manager. Each goal has one or more objectives identified as a means to work towards and achieve goal. There are several common goals that many client's receiving case management services have. Clients often have a financial goal which typically focuses on obtaining or increasing their income whether that is through employment or applying for disability benefits as well as applying for entitlements they may qualify for such as LINK. Many of our clients receive social security disability income and often require a representative payee. Trilogy offers representative payee services which includes client's completing a monthly budget with their case manager to ensure all their basic needs are met. Client's commonly have a goal around getting linked to medical providers, specifically primary care and psychiatry. In addition several clients have a medication goal including help with obtaining needing prescribed, receiving support with getting refills from the pharmacy, and help with learning how to take medications as prescribed. All of our clients set goals around their specific mental health symptoms such as depression, anxiety, mania, psychosis etc. including help identifying those symptoms, learning healthy ways to cope with them, and decreasing their overall severity and impact on daily functioning. Progress towards goals are tracked and measured within the IM+CANS assessment. Upon review of the IM+CANS staff and client assess client's progress towards goals and modify them as necessary. Goals are discontinued when they are met or no longer need to be worked on. If a goal is continued, staff indicated if limited, moderate, or significant progress has been made and why.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

Depending on the level of care a client is receiving dictates how often their treatment plan is revised. At our highest level of

care, treatment plans are revised every 3 months. At all other levels of care, they are reviewed every six months. In the review process a case manager and client meet to complete a full update and revision to their IM+CANS assessment documenting any and all changes and updates that have occurred in past three/six months. The case manager and client together go through each individual goal and its respective objective and evaluate and document the progress or lack of progress towards goal. The case manager and client assess and document in narrative form in the IM+CANS review what has contributed to progress, or lack of progress, towards this goal. At that time case manager and client have the opportunity to alter goals and objectives to ensure client has a treatment plan with realistic and achievable goals that meet their needs and treatment desires. In addition case manager and client have the opportunity to identify and set new goals.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

A client's pattern of engagement can vary throughout their length of treatment depending on their needs and level of care. At our highest level of care (Assertive Community Treatment), a client may see their case manager up to 7 days a week to address a variety of tasks such as receiving their medication, receiving budget money, going to the grocery store, attending a doctor appointment, or receiving assistance in their apartment with independent activities of daily living such as cleaning or doing laundry. Client's engaging in a lower level of care (Community Support Team) may only require approximately 3 case management appointments each week due to being higher functioning and/or more independent. Clients at our lowest level of care (Recovery Services) may only need to meet with their case manager once a week or every other week. Depending on the reason for the appointment, they may last anywhere from 30 minutes to several hours. Progression in the case management relationship looks different from client to client at Trilogy as we serve some individuals at a various levels of functioning and independence. Generally speaking progression can be a decrease in appointments times and/or frequency. A significant progress leads to a drop to a lower level of care.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

For every case management appointment a case manager is required to complete a case note. For each case note, the case manager selects the goal and objective addressed worked on during the appointment. The case manager is required to detail symptoms a client displays during appointments, what problems were addressed, what their specific intervention was as the case manager, why the intervention was necessary, and the client's response to this intervention. Case notes are reviewed by upper management to ensure quality of service and documentation.

**18. When does a client graduate from or complete case management services? Include any "check-in" or follow up with those clients.**

A client may complete case management services once they have determined they are no longer interested in services or once all of their goals have been met and they are no longer in need of case management supports. None of Trilogy's services are time limited. In addition, because we have several different levels of care at Trilogy and client may transfer between these levels based on case management needs. For example, should a client who is seen 6 days a week no longer need this frequency and intensity of case management services due to goals being met and increased independence, they can transition to a lower level of care where they only meet with their case manager twice a week. If they progress more they can transition to the lowest level of care and only be seen once a week or every other week. Conversely, should their case management needs increase they can transfer to a higher level of care.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the barriers to receiving those services?**

In order to achieve many of their goals in their service plans, participants often need services focused on management of their mental health symptoms. Such services include individual therapy, group therapy, psychiatric services, medication management, and case management. Those living with severe and persistent symptoms of depression, anxiety, mania, psychosis etc. face increased difficulty with managing day to day life including maintaining employment, attending doctor appointments, going to the grocery store, taking medications, managing finances, or keeping up their home/locating housing options. Barriers to symptom management include not knowing what services for symptom management are available, where to find them, how to access them, or being able to pay for such services.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

We receive referrals via our intake line, 24 hr community crisis line, email inquires through our website, walk-in hours for intake, police officers, schools, community members, hospitals, private practice therapist, community health clinics, other social service agencies unable to accept new referrals, and client's self referring. We receive many referrals for Evanston residents through Connections For the Homeless and St Francis Hospital. Majority of our services being accessed through these sources are our case management services as well as individual therapy. Of our case management services people are most commonly being preferred for supports with housing, linkage to psychiatric services, assistance with managing medications, and support with applying for disability income through social security and/or providing representative payee services to those who receive SSI and SSDI. Clients are connected to these services by them directly contacting us directly via phone, email, or through our walk-in hours and scheduling and intake and assessment. In cases where a client is being

referred by a family, friend, provider, police officer etc. we outreach the client via phone or in person to introduce ourselves and engage them in services. Once a client has scheduled an intake and assessment themselves, or we have done so following an outreach attempt, the intake specialist conducts that intake and assessment and facilitates immediate linkage to a case manager. All referrals and encounters with a client leading up to their connection to case management services is documented through our Intake Tracking system in our electronic medical record, Carelogic. Intake Tracking allows us to see any history of a client being referred for services, who referred them, what they were being referred for, and the outcome of that referral.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

Trilogy has a partnership/MOU agreement with St. Francis Hospital. The purpose of the partnership is to provide quality discharge planning which includes linkage to behavioral health supports post discharge from an inpatient psychiatric or ER setting. Our hope is to minimize high utilization of emergency services by providing linkage to community-based behavioral health services so that patients can easily access the services they are most in need of instead of returning to high-cost public services such as ER's. Trilogy's presence in Evanston focuses on streamlining access and linkage to community services by being directly on-site and further reducing duplication of services, inefficiencies and recidivism.

We have a service agreement with the Evanston Community Foundation to provide intake services in the Evanston community. This agreement allows us to embed an Intake Specialist in a local shelter to provide intake and assessment services to meet the behavioral health needs of those residing at the shelter. It is our goal to be able to expand such services to be able to identify various 'access points' across Evanston to ensure ease of access to care so that individuals do not need to utilize other high cost services such as ERs/hospital settings. It is through these access points and interfacing with the community and providers that stigma is reduced and access to help is more readily available.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

Trilogy is a private not-for-profit behavioral healthcare organization with six offices in Chicago. Our northernmost office lies on the border of Chicago and Evanston.

Trilogy's mission is to assist people in their recovery from mental illness by helping them discover and reclaim their own capabilities, life direction and well-being. Central to the philosophy of all Trilogy services is a belief in the possibility of long-term recovery from mental illness and mental illness with co-occurring substance use issues. We operate under the assumption that people can and do make good choices for themselves when offered accurate information, a wide array of recovery options, acceptance, and support. Our services are designed to maximize individuals' independence, self-sufficiency, and quality of life by helping people identify their own strengths, talents and interests and to develop their own wellness recovery plans.

Trilogy makes a significant effort to ensure that peers are well-represented throughout the organization. There are 14 individuals on the Board of Directors some of which can be described as primary or secondary consumers, which helps ensure that the consumer viewpoint is articulated and represented. Trilogy currently employs 30 primary consumers, most of whom are service providers and several frequently speak at presentations and on panels across the country about the impact that working as peer specialists at Trilogy has on them and the people we serve.

During FY 2020, Trilogy's Board of Directors, with the input of senior staff, updated the organization's strategic plan for the period from 2020 to 2023, which is included as supplemental information in the documentation section.

Trilogy's Board of Directors is comprised of members from Chicago and the suburbs. The Board oversees the President and CEO, assures that the long-range goals of the organization are being met, and works with senior staff through committees, including Finance, Development, Program Quality, and Human Resources.

Trilogy's Intake Department, displayed in the attached organizational chart, is overseen by the Director of Intake, Megan Miller. The Intake Department is a key segment of the clinical services provided by Trilogy, essentially the warm welcome to Trilogy services to potential clients. Additional services overseen by other senior staff include Williams and Colbert Implementation (consent decrees to assess and move nursing home residents into the community), Occupational Therapy, Youth and Family Services, Integrated Health Care, Outpatient Services, Intensive Outreach Services, Residential Services, Peer Services, Employment Services, and Integrated Dual Disorders Treatment.

In Sept 2020 Trilogy hired a Director of Equity, Diversity and Inclusion to lead our efforts to define, understand, assess, foster, and cultivate diversity within our organization.

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

Government contracts and grants comprise 95% of Trilogy's funding. As such, Trilogy implements and follows robust procedures and policies for documenting services, eligibility of costs and procurement.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

Each year Trilogy conducts a Client Satisfaction Survey. Client are provided the opportunity to anonymously complete either a physical copy or electronic copy of the survey which solicits information about their satisfaction with the intake process as well as their satisfaction with the programs and teams they receive treatment from. The results of this survey are compiled and shared with both clients and staff members. Trilogy utilizes this feedback to expand upon aspects clients have rated highly and address areas where we need to improve. In addition, clients have the right at any time to file a grievance should they be dissatisfied with their services. The grievance is reviewed by upper management and client is given the opportunity to have a meeting with upper management to express themselves and come to an agreed upon resolution.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

Trilogy's leadership team consists of 39 individuals. Of the 39 individuals, 82% are female and 18% are male. In regards to race, 80% are Caucasian, 15% are African American, and 5% are Asian. Trilogy acknowledges our leadership team is disproportionately Caucasian and the limitations that come with it. In order to increase engagement of people of color in decision making, our CEO and clinical leadership team conduct monthly workgroups to engage staff from all levels, backgrounds, and service areas from across the agency to discuss client needs, agency initiatives, and our strategic plan. The purpose of these workgroups is to gather information and ideas from front line staff regarding the community needs and to gather feedback about the direction of our agency. In regards to tenure, 13% have been a part of the leadership team for 8 or more years, 13% for 4 or more years, 20% for 2 or more years, and 54% for approximately 1 year or less. Trilogy has grown significantly since our 2019 application. Since October 2019 we have added 25 positions to our leadership team which accounts for over half of the team's tenure being 1 year or less.

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

040888943

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

Yes

No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

IF "YES," ENTER "NA."

N/A

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

Services are provided in community within the City of Evanston. Care Coordinator's office is located in the main office, 1400 W. Greenleaf, Chicago

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

Samantha Handley, President and CEO

**Budget** [top](#)

<b>Funding Sources/Revenues</b>	2020	2021	2021 Committed
City of Evanston Funding Request	USD\$ 30,000.00	USD\$ 30,000.00	USD\$ 0.00
St. Francis Grant	USD\$ 50,000.00	USD\$ 0.00	USD\$ 0.00
Medicaid FFS Billing	USD\$ 0.00	USD\$ 34,695.00	USD\$ 0.00
Evanston Community Foundation	USD\$ 0.00	USD\$ 15,000.00	USD\$ 0.00
<b>Total</b>	<b>USD\$ 80,000.00</b>	<b>USD\$ 79,695.00</b>	<b>USD\$ 0.00</b>

<b>Funding Uses/Expenses</b>	2020	2021 Total	City Funds
Mental Health Care Coordinator	USD\$ 43,500.00	USD\$ 47,500.00	USD\$ 24,677.00
Fringe Benefits	USD\$ 9,383.00	USD\$ 10,246.00	USD\$ 5,323.00

Travel	USD\$ 750.00	USD\$ 500.00	USD\$ 0.00
Supplies	USD\$ 300.00	USD\$ 300.00	USD\$ 0.00
Occupancy	USD\$ 3,435.00	USD\$ 3,435.00	USD\$ 0.00
Training	USD\$ 145.00	USD\$ 145.00	USD\$ 0.00
Indirect/ Administrative Costs	USD\$ 16,265.00	USD\$ 17,569.00	USD\$ 0.00
<b>Total</b>	<b>USD\$ 73,778.00</b>	<b>USD\$ 79,695.00</b>	<b>USD\$ 30,000.00</b>

## Budget Narrative

Trilogy's \$30,000 funding request to the Evanston Mental Health Board (EMHB) equals the request submitted in 2020 but \$300 higher than actual award. However, the total costs associated with providing this service remains relatively constant. EMHB enables program to provide non-Medicaid funded services such as outreach and engagement as well as ensure that any Evanston resident in need of mental health services can access services, funded or not. This funding is vital to our ability to provide comprehensive coverage.

Details of Funding Request below:

**Mental Health Care Coordinator:** This position provides direct services in the community as described in the program narratives. The annual salary for the current person in the position, Ms. Kelly Jones, is paid an annual salary of \$47,500. We are requesting that \$24,677 of her salary be funded by EMHB to enable Trilogy to deploy her efforts at that rate to support grant activities.

**Fringe Benefits:** Trilogy provides Fringe benefits to all staff at an estimated rate of 21.57%

- FICA: 7.65%
- Unemployment Insurance: 0.5%
- Workers Compensation: 1.58%
- Health Insurance including Employer share of Dental and Vision: 11.84%

**Supplies and Training:** These line items will also not be budgeted in this year's application as Trilogy is confident that costs savings can be achieved through shared costs and price negotiations.

**Occupancy:** This line item will also not be budgeted in this year's application due to funding limitations. This program's home office is located in our main building at 1400 W. Greenleaf and costs listed in budget represents this program's share of maintaining operations of building.

**Travel/ Mileage Reimbursement:** Trilogy reimburses staff at 57.5 cents per mile for travel with their own vehicles. The EMHB Coordinator currently averages about 70-75 miles of local travel per month. (72.46 miles x \$0.575 x 12 months = \$500)

**Indirect Costs/ Administrative Costs:** Trilogy has a Federally Negotiated Indirect Cost Rate of 28.28% against Modified Total Direct Costs. This line item is not budgeted in this year's application due to funding restrictions.

Trilogy currently does and will continue to provide services to the City of Evanston and will do so through a variety of funding sources such as Medicaid Fee for Service billing revenue and Evanston Community Foundation. EMHB funding will allow us to dedicate capacity to Evanston in terms of time spent, services rendered (non-billable) and people served (non-funded.)

The cost of operating this program is expected to increase by at least \$5,000 in the coming year due primarily to salary increase and increased overhead allocations. While EMHB funding and Medicaid Fee for Services is not expected to change drastically, the addition of grant funding from Evanston Community Foundation will allow the program to be less dependent on providing services restricted by Medicaid guidelines and allow the Mental Health Coordinator more freedom to provi

## Program Outcomes [top](#)

### Program Outcomes

Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
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1	Complete mental health assessments for 75 Evanston residents.	Completed IM+CANS assessments.	40	35	75	0
2	Complete 60 individual recovery plans and "soft handoff" of client to Trilogy recovery teams.	Completed individual recovery plans.	30	30	60	0
3	Refer 32 Evanston residents to outside service providers.	Completed outside referrals.	15	16	31	0
4	Have 55 Evanston residents visit the Trilogy Beacon, the organization's drop-in center.	Beacon attendance and use of facilities (computer lab, job search assistance, social activity, etc.).	27	28	55	0
5					0	0
<b>Total</b>			<b>112</b>	<b>109</b>	<b>221</b>	<b>0 0 0</b>

### Program Line Item Expenditures

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0

14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

**Documents** [top](#)

<b>Documents Requested *</b>	Required?	<b>Attached Documents *</b>
REQUIRED FOR ALL EXTERNAL APPLICANTS. Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.	✓	<a href="#">Trilogy Audit</a>
		<a href="#">Trilogy 990</a>
REQUIRED FOR ALL EXTERNAL APPLICANTS. Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.		<a href="#">Trilogy AR/ Strategic Plan</a>
Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).	✓	<a href="#">Trilogy 501c3</a>
Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).		
Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).		
Brief biographies of key staff including demographic information.	✓	<a href="#">Trilogy Staff Bio</a>
Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).		
Supplemental information relating to your program or agency, as applicable.		<a href="#">Trilogy Example Case Note</a>
Form used to document income of participants to establish eligibility.		
HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants. <a href="#">download template</a>		
Policies/procedures for case management process and case file documentation/maintenance.		
REQUIRED FOR ALL EXTERNAL APPLICANTS. Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.	✓	<a href="#">Trilogy Chart of Accounts</a>
Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.		
REQUIRED FOR ALL EXTERNAL APPLICANTS. Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).	✓	<a href="#">Trilogy FY20 Operating</a>
Organizational commitment to equity, diversity and inclusion.		
Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AML at time		

of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[Trilogy FY21 Budget](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached form.



[Trilogy COI](#)

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Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.



[Trilogy Benefits Form](#)

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Application ID: 350138

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City of Evanston  
Community Development  
**FY 2021 Case Management Services**  
Deadline: 4/21/2021

## Youth Job Center, Inc. Case Management

Jump to: [Application Questions](#) [Budget](#) [Program Outcomes](#) [Documents](#)

**USD\$ 50,000.00** Requested

Submitted: 4/21/2021 12:45:07 PM (Pacific)

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## Application Questions [top](#)

### 1. How do individuals or households with complex needs get enrolled in your case management services? Are participants referred by other entities (school social workers, police departments, other social service agencies)? If so, what percentage of new clients are referrals and what are main referral sources?

Youth and young adults enter Youth Job Center's (YJC) programs by walking into YJC's main office at 1114 Church Street or the agency's satellite office at Evanston Township High School, signing up online for Work-Readiness Training (WRT), through referrals with partner organizations, or calling YJC's intake line. All prospective participants take part in an interview with YJC's Enrollment Specialist, who compiles a comprehensive participant profile—including demographic data, education and employment history, skills and career interests, existing challenges/barriers, and needed support services. Internally, YJC conducts pre- and post-career readiness assessments for incoming participants to assess the effectiveness of its training activities. Additionally, all young people entering Career Pathways programs take the CASAS test to determine the need for additional supports as they begin their vocational training. YJC never turns away any young person and strives to serve youth "where they are at."

90% of young people who come into YJC services are referred by friends, family, and other community-based organizations. In Evanston main referral sources include City of Evanston's Youth and Young Adult Division, Evanston Township High School teachers, counselors, and staff, Curt's Café, Moran Center, Connections for the Homeless, and District 65 staff, teachers, and counselors. YJC meets regularly with community partners to provide information and to cultivate relationships with service providers.

The purpose of this program is to intentionally deepen partnerships within the Evanston Collective: Youth Job Center, Moran Center, Curt's Café, Connections for the Homeless, PEER Services, Infant Welfare Society, City of Evanston Youth & Young Adult Division, Y.O.U, and Erie Family Health Services. Justice-involved and homeless youth and young adults in the Evanston community will be brought into this web of services through this intentional collaboration and information sharing. Referrals from partner agencies will go to a point person at Youth Job Center who will function as the lead coordinator of services among the Collective. This YJC lead will ensure that a young person has the supports they need to initiate the journey that will lead to success in work and life.

### 2. Describe how agency/staff engage underrepresented populations and how City funds would improve equity of service delivery and/or expand capacity to underserved populations.

YJC engages youth and young adults in Evanston in a robust set of employment services that help young people explore

career paths, build employability skills, access supportive services to address external challenges, improve financial habits, and secure employment with a living wage and career advancement potential.

Funding from the City of Evanston would improve YJC's equity of service delivery and expand capacity by providing additional funding to support the agency's work with 20 justice involved and/or homeless youth and young adults, who the agency will serve in partnership with the James B Moran Center and Curt's Café. This initiative, "Plugged In: Connecting to Economic Opportunity (CEO)," is a concentration of YJC's Core Services for young people who are justice involved and/or homeless in an integrated service delivery that is administered by YJC, and a collaboration principally between Curt's Café, and The Moran Center, with the Evanston Collective as supporting partners.

Once a justice-involved or homeless young person is referred to YJC, YJC staff will create a referral plan with partners to address the individual's highest needs first. If a young person is homeless, YJC and Curt's will work with Connections for the Homeless to ensure housing is secured before the participant enters training. If a young person is justice-involved, YJC will make an immediate referral for legal services through Moran Center. Following this initial assessment and referral phase, YJC will enroll youth and young adults in Curt's Café's 90-day work and life skills training program. Coordination of services will continue during this phase and Curt's Café staff and YJC staff will regularly collaborate to ensure the young person receives every support they need. Concurrently with Curt's training, young adults will be referred to the James B. Moran Center for legal support, engaging them in restorative justice and Know Your Rights workshops, and providing legal assistance and supports.

Upon completion and graduation from Curt's Café's program, young people will transition to YJC for its employment and training programs. YJC will provide participants with Work Readiness Training (WRT), which is detailed later in this request, career exploration, paid internships, job placement, access to Career Pathways programs in 40+ occupations, and continued retention support for up to two years after participants have secured employment.

This program will have multiple entry points, with participants being referred to the partner that is best suited to meet their needs, with each organization supporting 20-25 young people and all partners serving roughly 30-40 youth and young adults combined. The major outcome of this work will be helping young people experiencing homelessness or criminal justice involvement step on to the path to stability and employment, gain access to community supports, and develop the knowledge of how to overcome these challenging barriers

**3. Are you turning people who are eligible away? If so, how many and why? Does the agency maintain a wait list, and if so, approximately how many people are on it?**

YJC serves every young person who requests our support, turning no eligible young person away.

**4. Does demand fluctuate throughout the year? If so, please explain.**

Demand for YJC programs does fluctuate throughout the year, with spring and summer traditionally being the two busiest periods of the year for the agency as young people graduate from high school and look for summer / permanent employment.

**5. Who participates in or benefits from the case management relationship? Describe participants in terms of age, gender, race/ethnicity, family status, income level and other relevant or defining characteristics (describe household unit - individuals or families). Include any eligibility requirements.**

YJC programs and services are available to any youth and young adult between the ages of 14-25, striving to serve every youth "where they are at." Additionally, the agency makes it a priority to recruit and support young people from communities that are underrepresented and lack sufficient resources. For this program YJC will serve under-represented, high-need individuals who are homeless or justice-involved.

As an agency in FY20 YJC served roughly 1,600 youth and young adults. This is a decline compared to FY19, which the agency attributes to the impact of the Covid-19 Pandemic that forced the agency to suspend many programs in spring and summer 2020, which are traditionally two of the agency's busiest periods. Of those served in Evanston in FY20, 72% were low low-income (less than 30% of median income), 16% were low-income (less than 50% of median income), 10% were moderate-income (less than 80% of median income), 2% were high-income (80% + of median income) For all YJC served in FY20 75% were low low-income (less than 30% of median income), 10% were low-income (less than 50% of median income), 3% were moderate-income (less than 80% of median income), 1% were high-income (80% + of median income), and 11% either didn't know their income or chose to withhold that information.

In Evanston in FY20, 60% of participants served were Black or African American, 20% were Hispanic / Latino, 17% were White, 2% were Asian, and 1% were two or more races. Of all YJC participants, 34% of participants served were Black or African American, 36% were Hispanic / Latino, 13% were Asian, 4% were two or more races, 5% were White, 2% were American Indian / Alaskan Native, 4% were various other races, and 2% chose to withhold that information.

Of all YJC participants 50.3% were female and 49.3% were male, and .4% were Trans or Nonbinary. 91% of participants served were Chicago residents, 7% were Evanston residents, and 2% were residents of various other suburbs in Cook County.

Currently 22% of participants receive Government Assistance, 4% of participants have experienced unstable housing, 3.9% have an IEP (Individualized Education Plan), 2.8% are justice involved, 2.8% have a documented disability, and 1.8% are parents. However, these barriers disproportionately affect Out-of-School Youth (OSY), with 35.7% of OSY receiving

Government Assistance, 20.2% having a documented disability, 19% being justice involved, 14.5% experiencing unstable housing, and 12.7% being parents.

**6. Complete the chart below with the unduplicated total of people expected to receive case management services in 2021, number who are low/moderate income, and the number who are Evanston residents. Provide the number of clients served in 2020.**

*Federal regulations do not allow CDBG funds to replace existing program funding. Programs funded in 2020 must show an increase in people served if applying for an increase in CDBG funding.*

1600	Unduplicated people to be served in 2021	Unduplicated people to be served in 2021
250	Unduplicated Evanston residents to be served in 2021	
1440	Unduplicated low/moderate income people to be served in 2021	
2025	Unduplicated people served in 2020	
205	Unduplicated Evanston residents served in 2020	
1202	Unduplicated low/moderate income people served in 2020	
180	Unduplicated low/moderate income Evanston residents served in 2020	
6,902.00	<b>TOTAL</b>	

**7. How many Evanston case management participants were enrolled as of January 1, 2021? How many new Evanston participants do you expect to enroll by December 31, 2021?**

YJC has 20 active case management participants who are justice-involved and 6 active case management participants who are homeless. YJC expects to enroll 10-15 more justice-involved youth and 4-5 more homeless youth in Evanston by the end of this year.

**8. Provide case management staff demographics including gender, race/ethnicity and tenure in role, qualifications and experience, including licensing and accreditation. Will new staff be hired and is this dependent on City funding?**

YJC staffing is not exclusively reliant on funding from the City of Evanston. The agency utilizes a variety of private, corporate, foundational, and government funds to support staff and programs. YJC Case Management staff who directly support our work in Evanston are: Rose Chavira, Peter Escobar, Rico Sanchez, and Amanda Marks. 50% of these staff are female and 50% are male. 75% are Hispanic / Latino, and 25% are White.

Rose Chavira serves as YJC's Career Pathways Career Advisor, working with youth to help them obtain licenses and credentials in fields related to their chosen career path. Rose obtained her Bachelor of Arts in Sociology and Spanish from Grinnell College. Before joining YJC, Rose served as a Case Manager for Howard Area Community Center's Career Readiness Program, managing a caseload of 70+ low-income and out-of-school youth. Rose has been a member of YJC's staff since March 2019.

Peter Escobar serves as a YJC Out-of-School Youth Career Advisor, working with youth who are disconnected from work and school. Peter provides Evanston youth with personalized career advising, job placement, an ongoing supplemental support. Prior to joining YJC, Peter worked as an Employment Coach for the Center for Changing Lives, working one-on-one with participants to develop their vision for employment and breaking that down into smaller, workable goals. Peter holds a Bachelor of Arts Degree in Psychology from DePaul University and has been a member of YJC's staff since July 2019.

Ricardo (Rico) Sanchez serves as YJC's Senior Manager of Programs and Partnerships, North, working with the Director of Programs and leadership team to develop and implement an annual operating plan and ensuring programs are aligned and staff are supported across geographic and program borders, and more. Prior to joining YJC, Rico worked at Youth Guidance as a Counselor / Curriculum Specialist for the Becoming A Man (BAM) program, administering the BAM curriculum, providing group counseling, and providing coaching to BAM Counselors. Rico holds a Masters in Social Work from Loyola University Chicago and has been on YJC's staff since November 2020.

Amanda Marks serves as YJC's Assistant Manager for Employer Relations. Amanda is responsible for building and sustaining trusting relationships with employer partners, soliciting feedback and engaging employer partners in program planning for continuous improvement, implementing best practices for training, placement, orientation, and more. Prior to her time at YJC, Amanda served as Community Engagement Associate at Cradles to Crayons. Amanda holds a Bachelor of Arts in Public Relations and Strategic Communication from Purdue University and a Masters in Nonprofit Management from DePaul University, and has been on YJC's staff since October 2020.

**9. What is the average caseload per case manager? How many case managers are on staff/how many participants are they responsible for?**

In YJC programs, caseloads vary depending on the intensity of the services provided. For CORE employment and training

services, YJC maintains caseloads at 100 per Career Advisor. For Career Pathways, caseloads average 25-30 per Career Advisor.

**10. Describe any recognized methods case managers use when working with participants (i.e. trauma informed care, strengths based assessments, motivational interviewing, participant informed goal setting, etc.)**

YJC's programs and services utilize an integrated service delivery model that incorporates a wide variety of recognized best practices, including trauma informed care, strengths-based assessments, participant informed goal setting, and more. YJC is a trauma-informed agency, with all program staff participating and completing the "Delivering Trauma-Informed Care," training provided by the Chicago Jobs Council. As a result of that training YJC developed common areas that are welcoming and where privacy is respected, reminds program participants that taking part in activities is their choice and they have complete control over what activities they do or do not participate in, engages youth in playing a significant role when it comes to planning and evaluating employment activities, provides an environment where youth feel validated and respectful boundaries are maintained, and uses a strengths-based approach to career planning and job placement, ensuring youth are passionate and engaged with their chosen career path.

Additionally, YJC CAs use a strengths-based model to assist youth in finding the career pathway that meets their needs, interests, and strengths, positioning the youth for success. Again building on youths' strengths, CAs then work with youth to help them develop the skills they need to successfully pursue their chosen career path.

YJC understands that young people are most engaged when they are pursuing goals that they are passionate about, and YJC Career Advisors (CAs) work with participants to develop detailed and actionable plans that clearly lay out the steps a young person needs to take to achieve their desired goals. While YJC Staff guide participants through this process, it is ultimately the participant that sets the goals for their Individualized Goal Plan (IGP). On a quarterly basis YJC staff conduct a formal review of the participant's performance to determine the effectiveness of the program and assesses the trajectory for each participant, deciding on next steps in the participant's career path. This adaptive practice empowers participants to inform programming support as they make decisions and set priorities about the course of their own career path.

**11. Does the agency provide training or opportunities for professional development? Is staff development offered internally or through external providers? How often are training opportunities provided? Is there a minimum level of training required? If so, please describe.**

YJC provides staff with a wide range of professional development activities, both internally and externally. In Winter 2020 YJC implemented its first ever professional development week, engaging staff and external partners to provide trainings on a wide range of topics including: cultural awareness; online skills training; setting and aligning expectations with participants and partners; maintaining focus in a virtual work environment; employer partnership; creating and refining your virtual presence; how to engage volunteers; building blocks to success; how to build credit; engaging and recruiting youth participants and partners; and personal and organizational branding.

These workshops were provided by YJC staff with relevant experience in the training topic as well as external partners like Al Tillery, an Associate Professor of Political Science at Northwestern University (NU) and the Director of NU's Center for the Study of Diversity and Democracy.

YJC also requires all program staff to complete the "Delivering Trauma-Informed Care," training provided by the Chicago Jobs Council. Additionally, YJC staff are encouraged to seek out and participate in external professional development activities, with staff free to participate in any training they find relevant as long as it does not interfere with their day-to-day responsibilities. Examples of professional development activities that staff have participated in include the Chicago Jobs Council's Coaching Fundamentals Bootcamp. In that four-part interactive virtual bootcamp, YJC staff build coaching values, skills and tools, and explore how to apply them in YJC's work with job seekers. Each highly interactive session includes coaching content, participatory learning activities, and discreet coaching practice in a peer to peer model bootcamp.

**12. Describe components of case management including the frequency/duration of meetings and enrollment for the average client. How is client engagement measured? What happens to participants who choose not to engage?**

Youth enter YJC's OSY programs by walking in to YJC's main site (Evanston), signing up online for YJC services, or calling YJC's intake line. Prospective participants take part in an initial interview with YJC's Enrollment Specialists, who compile a comprehensive participant profile—including demographic data, education and employment history, skills and career interests, existing challenges/barriers, and needed support services. YJC Enrollment Specialists are Masters of Social Work (MSW) candidates who are trained in motivational interviewing and social work practices. Enrollment Specialists administer a job-readiness assessment using a tool developed by YJC that determines the individual's baseline knowledge around employment acquisition and retention, including conducting a job search, writing a resume, interviewing, conflict resolution, customer service, and professionalism. YJC never turns away any young person and the pathway to a participant's success is always determined by his/her individual goals and needs.

After intake and assessment, a young person starts Work Readiness Training (WRT), a 10-hour intensive work and life skills course conducted over 2 weeks. During WRT a young person creates/updates their resume, learns and practices interview techniques, embarks on career exploration, creates employment and/or education goal plans, receives financial training and

creates a budget, experiences interactive lessons in conflict resolution, workplace communications and expectations, and graduates with a positive attitude and increased self-esteem. WRT graduates are positioned to succeed in their job search and in life after they graduate from Work Readiness training.

Following enrollment, a young person begins meeting 1:1 with their YJC Career Advisor (CA). These one-hour meetings happen often in the first few weeks as the CA and young person plan and lay the groundwork for the successful transition into employment or a training program. Following WRT graduation, a young person will meet with their CA for weekly check ins until they find employment in their chosen field. Additionally young people meet at least weekly with their Employment Relations Specialist who assists in connecting them with employment opportunities. YJC's team approach to serving participants means that young people have multiple resources to help them succeed.

Participant engagement is measured in a few ways. Regular case management meetings happen on a weekly basis and active participants are reviewed and action plans are created if needed. CAs meet weekly with their Program Supervisor to review data and ensure that case notes are thorough, current, and reflect engagement. For young people who do not engage, an action plan is created. A CA, their supervisor, or another staff person who may have had a key relationship with the young person will be activated to try to reestablish the connection.

**13. Describe the process for creating a service plan with participants. Are participants asked to provide any documents at intake? Or any documents required as part of the service plan?**

As part of YJC's Training Curriculum and Career Advising process, YJC CAs guide participants in developing detailed and actionable Career Plans that clearly lay out the steps a young person needs to take in order to achieve their career goals. As part of WRT, YJC provides a module that focuses on goal setting, including completion of a Smart Goal Plan (SGP). The SGP is designed to assist participants with identifying long-, mid-, and short-term goals, and the WRT module is designed to assist participants with thinking through the steps between the present and desired outcomes. In addition to employment and career goals, the SGP will set markers for stabilization (housing, childcare, financial, etc.) and education or certification where appropriate. The SGP is also used as a framework upon which the CA and participant build the more elaborate and in-depth Individual Goal Plan (IGP). Our retention model assists staff in identifying participants with strong potential to advance in their careers. Combined with the Illinois Worknet assessments to look deeper into industry trends, wages, wage progression, educational requirements, and employment outlook for careers of interest to each participant, YJC helps guide youth toward thinking beyond an entry-level position and finding positions in targeted growth industries.

Once a participant completes WRT they begin working with their CA 1:1. As part of that work participants utilize Illinois Worknet tools and assessments to explore a variety of careers based on their skills and interests and discuss options for arriving at their goals with CAs. Using a detailed Job Counseling and Placement Process checklist and building on the participant's assessment results, the CA and participant develop an initial IGP, a detailed plan that elaborates on the Smart Goal Plan (SGP) developed during WRT. The plan sets out the individual's career goals with clearly defined action steps, timelines, and target completion dates. For some this might entail achieving the appropriate license or participating in a certain training program. For others it might involve enrolling in an apprenticeship program once they have left school.

Through this process YJC participants learn where they can access necessary resources, how to set goals that are ambitious yet obtainable, how to put together a detailed plan that takes into account things such as timing, logistics, and finances, and also instills in them the confidence and self-efficacy that will allow them to persevere in the face of life's many challenges. YJC knows that it is not enough to simply help youth find a job, we must provide them with the tools needed to be independently secure so that they can continue to overcome obstacles throughout the course of their life.

**14. Describe a service plan a participant would create with their case manager (indicate common components such as budgeting, individual and professional goals, etc.). What are the typical outcomes of case management plans? How is progress toward achievement of goals tracked and success measured?**

When a young person enters YJC they begin the process of thinking and planning for their future. Every step along the way and every staff person they interact with is coaching them and supporting them to achieve their goals. When a young person goes through enrollment, they will discuss their initial goals with the Enrollment Specialist. These are recorded and picked up by a CA as they and the young person begin crafting employment and educational goals.

CAs and participants work together to tailor an array of workforce and educational development options to the participant's immediate needs (such as securing paid internships/employment as soon as possible for participants at financial risk), near- and longer-term objectives, and preferences. The CA also links participants experiencing structural and/or psychosocial barriers to employment to wraparound supports in the community through the Evanston Collective.

Goal planning at YJC is flexible by design and supports a young person's growth and development. The goal plan includes a Main Goal and asks a young person to articulate how they will know if they've accomplished their goal. They describe why this goal is important to them as well as the personal key strengths they bring to accomplishing the goal. They think through obstacles/barriers that may arise and reflect in advance on what they will do to overcome those obstacles. They describe what the benefits of achieving the goal are and finally they detail their next big steps to achieving the goal.

A young person then brings these initial goals to WRT and builds on them as they research more about their chosen career. In WRT they codify their goal plans and create budgets and life plans based on the career they have chosen.

YJC implemented a new data solution in the past year. One of the key performance indicators is designed to measure how well young people are progressing in the goals they have chosen for themselves. CAs perform regular check ins once a young person has created their goals to ensure that they are on track and to assist them to eliminate rapidly any barriers that may have arisen. These check ins occur weekly until a young person has secured a job or entered a training program. After that, check ins follow a retention schedule: 7 days, 30 days, 90 days, 6 months, 1 year and then 2 years after employment. YJC has over a 70% success rate placing young people into employment and into education programs.

**15. How often are service plans reviewed and revised? How are progress notes documented and how often?**

YJC CAs conduct a formal review of participants service plans on a quarterly basis. The purpose of the formal review is to determine the effectiveness of the program and assesses the trajectory for each participant, deciding on next steps in the participant's career path. This adaptive practice empowers participants to inform programming support as they make decisions and set priorities about the course of their own career path. YJC will aggregate this data and review it to determine the overall programs outcomes, using that information to modify program activities and outcomes as need to meet progress towards the proposed goals.

YJC staff document a participant's progress on their service plan by capturing data on an ongoing basis, using results to revise program activities and services provided. YJC staff will meet with program participants on a regular basis, using each meeting to informally gather information about the participants. During these meetings YJC staff will record and assess each participant's progress on factors such as housing stability or reliability of childcare and work with participants to tackle challenging barriers such as criminal record expungement, basic skills acquisition, and mental or physical differences that affect work opportunities. After participants have secured employment those informal sessions will also be used to review the progress the participant has made towards their goals and evaluate as their workplace performance, including employer feedback, attendance, and length of employment. Additional experiences, trainings and certifications completed during the program will be collected for their impact on opportunities available to youth.

This information is entered into the YJC's database, Exponent Case Management (ECM). YJC uses ECM to document ongoing program activities, participation, training, placement, retention, and contextual factors. This system also allows YJC to collect customizable demographic, process, output, and outcome information. Each participant is entered into the database capturing participant information, such as name, mailing address, telephone number, and social security number. It also collects demographic information such as date of birth, marital status, ethnicity, sex, living situation, income level, and parental status. Additional participant information collected includes education and job experience level. Every YJC staff person with programmatic or supervisory responsibility receives training in the use of ECM. The system creates reports with just a few mouse clicks and serves as a powerful internal management tool.

**16. Describe a typical client's pattern of engagement with their case manager/service plan, including frequency/duration of meetings and ongoing monitoring. Is there an "average progression" within the case management relationship?**

The typical participant's engagement with YJC staff and their case manager includes intensive interactions designed to support a young person on their journey to a successful career and adult life. As described above a young person will meet every day for the first 2-3 weeks with a YJC staff person – through enrollment, Work Readiness Training, into Career Advising and with the Employment Relations specialist they'll work with to find and secure employment. After the initial assessment, training, and planning are complete, young people meet with their CAs at least weekly for one-hour meetings. Additionally, they may meet with the Employment Relations Specialist weekly to conduct their job search. YJC also hosts Job Clubs weekly that young people can attend and they receive support during those from Employment Specialists, trained volunteers, and CAs.

Young people will continue to meet on a regular basis until they have secured employment or entered their chosen training/education program. Regular retention check ins follow employment placement and if any issues surface, a CA will immediately work to assist the young person as appropriate. Most young people who come to YJC to secure employment will find a job within a month of entering YJC's programs. YJC continues to engage with young people after placement and young people will often return for additional job placement, advancement opportunities, and further education as they look to advance in their careers.

**17. Describe the process for documenting and maintaining case records. Include uploaded sample form for documenting case notes (screen shots allowed) under the "Documents" tab.**

Effective documentation and evaluation processes are an essential element of all YJC activities. YJC has a strong data culture in place, with established policies and procedures for recording, measuring, and tracking a participant's program performance. YJC uses Exponent Case Management (ECM), a Salesforce based case management database, using the database to document ongoing program activities, participation, training, placement, retention, and contextual factors, as well as personal information relating to a participant's gender, race, and more. The agency begins collecting information from participants during the Intake and Enrollment phase of programs, capturing information around a participant's name, mailing address, telephone number, social security number, date of birth, marital status, ethnicity, sex, living situation, income level, and parental status. Additional participant information collected includes education and job experience level. YJC staff have regular

deadlines for submitting data to ensure that database is accurate and current, with the database automatically reminding YJC CAs when data is overdue. Every YJC staff person with programmatic or supervisory responsibility receives training in the use of ECM and this powerful internal management tool allows staff to create detailed reports with just a few mouse clicks.

Participant & Job Process Detail data recorded in ECM includes but is not limited to:

- Demographic data on youth served
- Number of youth receiving services
  - o Training: participation and completion
  - o Extensive support, e.g. career advising, supportive services, etc.
  - o Professional Certifications completed
- Number of youth placed in jobs
- Retention Support
  - o Participation in retention program first ten weeks of the job
  - o Job retention up to 2 years
  - o Attendance
  - o Employer feedback
  - o Promotions
  - o Gains in working hours or hourly wage
- Stabilization Gains (financial, housing, childcare, financial literacy, etc.)
- Progress against goals
  - o Preparing plan
  - o In process
  - o Changed Goal
  - o Withdrawn
  - o Attained
  - o Planning completed
- Other Support provided by Career Advisors

Evaluation information collect includes but is not limited to the following:

- Pre- and post-participation surveys in training
- On the job satisfaction
- Youth evaluation of support programs, participant assessment of whether YJC is helping them achieve goals they've set for themselves

Employer information

- Satisfaction survey for manager and incumbent training
- Customized program satisfaction
- Comparison to peer employees

**18. When does a client graduate from or complete case management services? Include any “check-in” or follow up with those clients.**

Participants effectively exit YJC programs when they have addressed any barriers to employment and have successfully secured employment with advancement potential in their chosen career path.

However, YJC's support for young people doesn't stop once they've secured work. YJC utilizes a two-year retention model, continuing to work with participants after they have completed program requirements and secured employment. YJC reaches out continuously and regularly during this period to monitor participant job performance and share information about hiring events, training programs, and other initiatives. Regular follow ups are scheduled at 7-day, 30-day, 90-day, 6 months, and one- and two-year intervals. Once CAs have helped participants secure initial employment, they provide continued support in partnership with employers to address workplace challenges and support these young adults in continued advancement. During this period CAs encourage participants to reach out for guidance, assistance in planning for further career and educational advancement, and for support in the event of a crisis that threatens job retention. Participants sign a waiver authorizing YJC CAs to speak directly with employers to monitor job retention, job performance, and address any issues that may arise. Incentives such as gift cards, transportation assistance, and invitations to YJC events help the agency maintain relationships with participants post-placement. Additionally, YJC sends emails, makes phone calls, uses social media, and texts all active participants in advance of hiring events and job fairs.

**19. List the services that participants most often need to achieve service plan goals and become self-sufficient. What are the barriers to receiving those services?**

YJC provides a wide range of employment services to youth and young adults in Evanston, with the agency personalizing support to meet the needs of each participant. While YJC provides a robust suite of services, the needs of most youth participants are met by the agency's basic employment programs and services.

YJC's services start with intake and assessment, with potential participants completing YJC's intake questionnaire, which

they agency uses to develop a comprehensive participant profile, complete with age, gender, race, ethnicity, educational attainment, employment experience, barriers, and more. Following intake participants are engaged in YJC's Work Readiness Training (WRT). WRT begins with an orientation to YJC and its programs. Participants receive training on the basics of getting a job, teaching youth how to build a resume, complete applications, and helping them practice and refine interviewing techniques in both individual and group settings. But these lessons are merely the starting point. Subsequent training modules incorporate skills development in areas of goal planning and career development, networking, team building, problem solving, financial literacy, digital literacy, basic entrepreneurial skills, workplace expectations, introductory computer and social media skills, customer service and communications skills, and more. Participants also take part in Illinois WorkNet assessments to help identify personality and career profiles.

Following completion of WRT, the participant meets with their CA 1:1 to review the goals and expectations of the program, administer the CASAS test to assess the grade-level equivalence of the participant's reading/literacy and math/numeracy skills, and schedule a follow-up appointment to review and confirm all eligibility documentation. Following that the CA and participant work together to enroll in apprenticeships or Career Pathways opportunities provided by local employers. Once that participant has completed their apprenticeship or Career Pathway the CA will then support them in securing paid internships or permanent employment, with YJC providing retention support for up to 2 years afterwards.

Of those served by YJC in FY20, 22% of participants received Government Assistance, 4% of participants experienced unstable housing, 3.9% had an IEP (Individualized Education Plan), 2.8% were justice involved, 2.8% had a documented disability, and 1.8% were parents. However, these barriers disproportionately affect Out-of-School Youth (OSY), with 35.7% of OSY receiving Government Assistance, 20.2% having a documented disability, 19% being justice involved, 14.5% experiencing unstable housing, and 12.7% being parents. Based on that data, the most common barriers youth experience are being low-income, having a disability, being involved with the criminal justice system, experiencing unstable housing, low educational attainment, and lack of childcare support.

**20. Describe the referral process, including how it is tracked. What services are generally accessed through referrals and how are participants connected to needed services?**

As part of YJC's Integrated Service Delivery model, the agency helps participants access an extensive network of wraparound supportive services. These services are essential as they help participants address and overcome significant external barriers that could prevent a young person from successfully engaging in employment opportunities or training programs. Additionally, in spring 2021 YJC implemented a Masters of Social Work internship program, through which the agency is able to provide participants with in-house basic mental health services and supportive service referrals for participants. Internally, YJC is also able to provide participants with transportation assistance and connections with adult mentors, and the agency utilizes a trauma informed approach for all programs. Via YJC's linkage network with the Evanston Collective, CAs also coordinate referrals to community resources including Connections for the Homeless (housing); Oakton Community College (GED); Moran Center for Youth Advocacy (records expungement); Erie Family Health Centers (health/primary care); and PEER Services (substance / alcohol abuse counseling). Participants receiving supportive services meet with their CA anywhere from 3-4 times per week to monthly or bi-monthly, depending on the participant's needs, with the CA using those meetings the assess progress in addressing barriers and to update the participant's Individual Goal Plan (IGP) as goals are met.

**21. Does the agency have service agreements, MOUs, and/or partnership agreements with other organizations? Describe the nature and purpose of agreements.**

YJC has an extensive network of partners that it works with to provide participants with access to supportive services and additional training opportunities. To clearly lay out the responsibilities of each of YJC's partnerships, the agency develops and secures detailed MoU's with its partners. The level of detail included in each MoU varies by partnership, but at a minimum every MoU contains detailed information around: overall program design; roles and responsibilities of each partner; each partner's funding contributions; and period and length of partnership. The purpose of these agreements is to ensure that each organization fully understands their roles and responsibilities and the associated costs involved with the provision of their services.

YJC partners with organizations throughout Evanston to support youth in achieving career success, with MoUs in place with Curt's Café, The James B. Moran Center, Oakton Community College, National Able Network, the City of Evanston, Youth and Opportunity United (YOU), Connections for the Homeless, Erie Family Health Services, PEER Services, Family Focus, and the Infant Welfare Society of Evanston.

**22. Provide a summary of the organization's history in Evanston and mission (including organizational structure, size and functions of the board); note any significant changes in the last year.**

*Under the "Documents" tab, attach the current Strategic Plan and a list of current Board members; add Board demographics including approximate age range, race/ethnicity .*

YJC has been providing employment services to young people in Evanston since 1983. YJC's mission is, "Success for young people in the workplace and in life." Today YJC is a leading youth workforce development agency in Cook County, providing thousands of youth and young adults throughout the region with personalized career advising, job training and placement, internships and work-based learning opportunities, wrap-around emotional-social services, and career advancement and retention supports.

Since 1995 YJC has provided the Summer Tutors Program, hiring local youth to serve as Teacher Assistants for Evanston

Skokie School District 65's (D65) Summer Schooling. This program was put on hold in 2020 and 2021 due to the Covid-19 Pandemic but YJC plans to resume the work once it is safe to provide in-person services again.

In 1999 YJC established a satellite office at Evanston Township High School, which still exists today. Through this office YJC provides ETHS students with postsecondary planning, career advising, employment skills training, and job placements with local employers. In 2020 YJC had to transition these services to remote implementation but the agency plans to resume in-person services as soon as its safe.

In 2003 YJC began providing services for Out-of-School Youth in Evanston, working with young adults who are disconnected from work and school to explore career paths, build employment skills, and secure meaningful employment with career advancement potential. This work continues remotely and in the last program year YJC served 294 disconnected youth and young adults, many of which were Evanston residents.

Starting in 2012 YJC partnered with D65 and the Evanston Public Library to administer the ABC Boosters Program. ABC Boosters hires local teens to work 1:1 with preschool youth to develop foundational literacy skills. Like the Summer Tutors program, YJC had to suspend this work in Summer 2020 due to the pandemic and will implement the program once it is safe to do so again.

Since 2019 YJC has been a leading member of the Evanston Workforce Alliance, a coalition of community-based organizations dedicated to creating sustainable change in Evanston's workforce development agencies and embedding collaboration and alignment in outreach, training, placement, data collection, and sharing results for citizens of Evanston. Through the Alliance, YJC and its partners better connect Evanston youth with local employment opportunities and ensure young people in the community have access to resources that will help them thrive.

YJC's Board of Directors currently has 29 members, with a maximum of 30 stated in the agency's bylaws. The Board serves in a Governing capacity. YJC's Board of Directors committees include: Finance and Audit, Development, Communications, Programs, Human Resources, and Executive Committee, which is composed of officers and committee chairs. YJC's Board has four officers: Chair, Vice Chair, Treasurer, and Sec

**23. Describe your agency's capacity to document provision of services, including policies and procedures for managing finances and procurement.**

*Include experience with federal record keeping, eligible uses of funds, procurement and other requirements per the Omni Circular, 2 CFR, Chapters I & II, Part 200, et al (see Resources Library).*

YJC has strong documentation procedures in place and is fully capable of adhering to the documentation policies set in this funding opportunity, having successfully implemented CDBG, WIOA and IDHS funded programs for several years.

**24. Describe how your agency gets feedback from clients/participants and how that information is incorporated to improve services and service delivery.**

In addition to collecting information about a participant and their progress against set goals, YJC uses internal data analysis to improve program design and offerings, and outcome information and evaluation results are used to foster an environment conducive to continuous learning and improvement. As part of WRT, staff administer a job-readiness assessment that determines the individual's baseline knowledge around employment acquisition and retention. The agency utilizes additional pre- and post-assessment surveys and math / reading literacy CASAS testing to evaluate program effectiveness and measure growth in essential skills. CAs and mentors regularly record notes in the agency's database, detailing interactions, activities, contextual factors, and more. The agency also administers paid work experience evaluations to both the participant and the employer partner, gathering information about program strengths and weaknesses from both, allowing us to adjust program delivery to be more effective for both participants and employer partners. YJC uses this information to identify specific components of a successful program in the hopes of expanding the program to new populations or service areas, thus expanding our reach. Evaluation results that suggest a program is falling short of its goals are analyzed as opportunities to refine program components and that sometimes means taking a closer look at the staff's role in program delivery and identify areas for improvement to determine a more effective approach to serving youth. The agency recognizes that this approach is essential to success as the needs of the populations we aim to serve are constantly changing.

**25. Provide staff demographics including gender, race/ethnicity and range of tenure in role. How many staff members of color are in leadership/decision-making positions? If less than 25%, describe how the agency is engaging people of color in decisions?**

YJC prides itself on its diverse staff and the agency works to incorporate new perspectives whenever possible. YJC currently has 22 staff members. 27% are Black or African American, 27% are Hispanic / Latino, 33% are White, 9% are Multi-racial, and 5% are Middle Eastern. 64% of staff are female and 36% are male. Staff tenure ranges from 16 years to one month, with the average tenure being 2.75 years. At the director level, 25% of staff are Black or African American and at the Manager level 27% of staff are Black or African American, 27% are Hispanic /Latino, and 9% are Multi-racial.

YJC is dedicated to being a diverse and equitable organization that is inclusive for all. In November 2019 the agency stated this as a priority, with YJC hosting an all-staff retreat to decide upon the priorities the agency would pursue in the coming years. While staff identified many different priorities, that one that was clearest was that we as an agency need to do a better

job of improving equity, both internally, and in our work with young people. Following that retreat, YJC developed a staff Equity Team dedicated to identifying and implementing ways for YJC to improve equity for our participants, our staff, and in partnership in our communities. The Equity Team was scheduled to begin this work in Spring 2020 but the world as we knew it was about to change due to Covid-19. However, in the wake of the killings of Breonna Taylor and George Floyd YJC recommitted to integrating this work into our mission. To guide our efforts YJC is engaging its diverse staff in discussions about the lasting negative impact of these inequities on people of color, inviting staff to share their unique perspectives and experiences.

The agency's staff Equity Team is meeting regularly, making race the priority while also planning for future work in gender, age, ability, and more. Staff are working to better understand what it means to be a Person of Color in our society, how racism has become subtly ingrained in the institutions that shape our society, and what we can do as an agency to be a part of the solution. This is a long, challenging, and sometimes painful journey, but YJC would not make any other choice. Discussions have been open, honest, raw, and sometimes difficult to have. But they have also been wonderfully informative. As a team we are finding the balance between experiencing our feelings of sadness and anger over the current situation and working to develop productive solutions and strategies for driving this work forward.

Additionally, YJC has formed an Equity Committee of the Board of Directors, which is working closely with the staff Equity Team and the broader group of the Board of Directors. We have modified and approved our adaptive strategic plan to integrate an equity lens. We are considering how roles need to shift, and what YJC staff and board members can do as individuals and as an agency to push toward greater equity both inside and outside of our agency.

**26. All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA." All organizations receiving funds are required to have a DUNS number. Please enter your organization's DUNS number in the space below. If you do not already have a DUNS number, enter "NA."**

16-424-2687

**27. Is the facility and program in compliance with the Americans with Disabilities Act?**

Yes

No

**28. If "no," explain what areas are not compliant and what accommodations are made for individuals with disabilities. Describe your organization's experience making such accommodations.**

*IF "YES," ENTER "NA."*

NA

**29. Where (address/location) are services provided and how do participants get to the location or facility?**

YJC's main office is located at 1114 Church St. Evanston, IL 60201. Our satellite office at Evanston Township High School is located at 1600 Dodge Ave, Evanston, IL 60201. Both offices are accessible via public transportation.

**30. Certification: I certify that I am authorized by the Board of Directors or governing body to submit this application for 2021 City of Evanston funding and that, to the best of my knowledge, the information in this application is true and correct.**

Ted Carroll, Manager of Grants and Communications

## Budget [top](#)

Funding Sources/Revenues	2020	2021	2021 Committed
City of Evanston CDBG	USD\$ 23,338.00	USD\$ 50,000.00	
Annual Benefit/Other Events	USD\$ 144,349.00	USD\$ 150,000.00	
Individual Giving	USD\$ 149,176.00	USD\$ 200,000.00	
Philanthropic Grants	USD\$ 868,286.00	USD\$ 856,000.00	
Government Grants	USD\$ 443,518.00	USD\$ 647,118.00	
Other Revenue	USD\$ 6,112.00		
<b>Total</b>	<b>USD\$ 1,634,779.00</b>	<b>USD\$ 1,903,118.00</b>	<b>USD\$ 0.00</b>

Funding Uses/Expenses	2020	2021 Total	City Funds
Salaries and Benefits	USD\$ 1,360,744.00	USD\$ 1,421,531.00	USD\$ 30,000.00
Grants and Contract Expenses	USD\$ 122,823.00	USD\$ 248,070.00	USD\$ 20,000.00
Benefit/Other Expenses	USD\$ 11,467.00	USD\$ 35,000.00	
Depreciation	USD\$ 27,488.00	USD\$ 34,856.00	

Occupancy	USD\$ 43,731.00	USD\$ 48,300.00	
General and Administrative Expenses	USD\$ 136,098.00	USD\$ 157,900.00	
<b>Total</b>	<b>USD\$ 1,702,351.00</b>	<b>USD\$ 1,945,657.00</b>	<b>USD\$ 50,000.00</b>

## Budget Narrative

Youth Job Center's fiscal year runs from July 1 to June 30th. In FY21 YJC has worked to increase its budget, successfully engaging additional funders and continuing to expand on its services for young people, integrating a wide variety of financial services, including budget coaching, credit counseling, access to income supports, and more into its training curriculum. Additionally, the agency has integrated basic digital skills development into its curriculum, reflecting the increased importance in digital skills competence that has become increasingly essential in today's economy.

The agency's proposed budget and request for support reflect the YJC's growing focus on serving those in our community with the most significant needs, specifically homeless and justice involved youth and young adults. Support from the City of Evanston would support YJC in providing these young people with the in-depth training and support they need to overcome significant external challenges. YJC is already working to serve this population but support from the city would improve YJC's and its partners in the Evanston Collective, specifically Curt's Café and the James B. Moran Center, ability to meet this populations intensive needs. The staff who will support this work are already currently in place and funding from the city would bolster government funding received from the Workforce Innovation and Opportunity Act and the State of Illinois Department of Human Services, providing additional support specifically for Evanston youth and young adults.

## Program Outcomes [top](#)

### Program Outcomes

	Outcome	Indicator (How was success measured?)	Goal # (G): Jan-June	G: July-Dec	Goal Total	Actual # (A): Jan-June	A: Jul-Dec	Actual Total
1	YJC and partners will enroll 25-30 justice involved and homeless young adults.	Participants complete the enrollment process and participate in initial goal setting and assessment. Participants engage with partners to immediately put supports in place.	5	25	30			0
2	20-25 youth participants will complete and graduate from Curt's Café's 90 Day Program.	Participants complete the Curt's Café 90-day program, receiving work and life skills training, experiential learning, and access individual social service support.	5	15	20			0
3	20-25 youth and young adults will receive legal supports through the James B Moran Center	Participants complete Restorative Justice Workshops, Know Your Rights workshops, and access legal assistance and supports.	5	15	20			0
4	20-25 Youth receive Youth Job Center employment services, including training, advising, placement, and ongoing support.	Participants complete Work Readiness Training, receive personalized career exploration guidance and advising, secure placement in an internship, paid work experience, apprenticeship, or Career Pathways program, and receive continued retention support for up to two-years after exiting the program.	5	15	20			0
5	20 youth graduate the program and have developed connections with a minimum of 3 members of the Evanston Alliance for support after the	20 participants complete the program and have taken significant steps towards improved stability, employment, have gained knowledge about supportive services and have ongoing access to community supports.	5	15	20			0

program.

<b>Total</b>			<b>25</b>	<b>85</b>	<b>110</b>	<b>0</b>	<b>0</b>	<b>0</b>
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### Program Line Item Expenditures

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

### Program Line Item Funding

Item Description	Total Budget	City of Evanston Funds	Jan-June	July-Dec	Spent to Date
1					\$ 0
2					\$ 0
3					\$ 0
4					\$ 0
5					\$ 0
6					\$ 0
7					\$ 0
8					\$ 0
9					\$ 0
10					\$ 0
11					\$ 0
12					\$ 0
13					\$ 0
14					\$ 0
15					\$ 0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>\$0</b>

#### Documents [top](#)

#### Documents Requested \*

REQUIRED FOR ALL EXTERNAL APPLICANTS.  
Audited financial statement, federal single audit (if applicable), and Form 990 for the most recent completed fiscal year.

#### Required? Attached Documents \*



[YJC FY20 Audited Financial Statements](#)

[YJC Form 990 - 2019](#)

REQUIRED FOR ALL EXTERNAL APPLICANTS.

Most recent annual report or a summary of the organization's prior year's activities and accomplishments including strategic plan.

[YJC FY20 Annual Report](#)

[YJC 2021 Revised Strategic Plan](#)

Federal 501(c)(3) letter of determination verifying tax-exempt status (NEW APPLICANTS and agencies that have not received CDBG or MHB in the last two years).



[YJC Federal 501\(c\)\(3\) letter of determination](#)

Non-discrimination & equal employment opportunity policies, and Affirmative Action Plan (new applicants or previously funded agencies only if changed).

Articles of incorporation/bylaws (new applicants or previously funded agencies only if changed).

Brief biographies of key staff including demographic information.



[YJC Brief Biographies of Key Staff](#)

Plan to address accessibility issues, including who to contact with questions/issues, policies for responding to grievances/complaints and the time period for a written response (new applicants or previously funded agencies only if changed).

Supplemental information relating to your program or agency, as applicable.

[YJC - Evanston Collective MoU](#)

Form used to document income of participants to establish eligibility.

HUD Family income limits used to determine eligibility funding and for reporting demographic characteristics of participants.

[download template](#)

Policies/procedures for case management process and case file documentation/maintenance.

REQUIRED FOR ALL EXTERNAL APPLICANTS.



[YJC Chart of Accounts](#)

Chart of Accounts used to define each class of items for which money or the equivalent is spent or received, and to organize and segregate expenditures, revenue, assets and liabilities.

Budget detail - if the form on the budget tab does not have enough lines to break out each funding source of \$20,000 or more, attach detail for categories such as Foundation Grants here.

REQUIRED FOR ALL EXTERNAL APPLICANTS.



[YJC - Statement of operating revenues and expenditures for most recently completed fiscal year](#)

Statement of operating revenues and expenditures for most recently completed fiscal year (not required for City programs).

Organizational commitment to equity, diversity and inclusion.

Section 3 New Hire Certification: To be used for any new hire who has an income below 80% AMI at time of hire, for job that does not require more than a H.S. diploma unless on the job training is provided.

Current year agency operating budget.



[YJC FY21 Organizational Budget - Concise](#)

Board of Directors, including demographic information, professional affiliations and home address. If a regional organization with a local board of directors, attach listings of both boards.

[YJC Board List FY21](#)

Conflict of Interest Disclosure. City of Evanston and Federal policies require the disclosure of any possible conflict of interest in the provision of Federal or local funding. Complete and upload the attached



[YJC Signed Conflict of Interest Disclosure](#)

form.

[download template](#)

Duplication of Benefits form. City of Evanston and Federal policies require the disclosure of any duplication of benefits in the provision of Federal, state or local funding. Complete and upload the attached form.



[YJC Duplication of Benefits Form](#)

[download template](#)

\* ZoomGrants™ is not responsible for the content of uploaded documents.

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